CLEAR FORM

TRIANGLE PHYSIOTHERAPY & REHABILITATION

www.trianglephysiotherapy.com

MALE PELVIC HEALTH SUBJECTIVE HISTORY FORM

PATIENT INFORMATION

Last Name:	First Name:	
Date of Birth:		
Apt/Suite/Unit No:	Street:	
City:	Postal Code:	
Home Tel. #:	Work Tel. #:	Cell #:
*E-mail:		Occupation:
Referring Physician:	Telephone:	

Sports/Hobbies:

Relative Activity Level ☐ Sedentary ☐ Active

Reason for consultation:

Pertinent reports:

Medical diagnosis:

Symptoms:

Change in symptoms:

HOW DID YOU HEAR ABOUT US? (MARK ALL THAT APPLY)

☐ I have been here before ☐ Doctor's Referral ☐ Yellow Pages Book ☐ yp.ca ☐ Google search
☐ Friend/Family/Co-Worker (please name)_____ ☐ Sign Board
☐ Just Walked In ☐ Flyer ☐ VennGo ☐ Other: _____

MEDICAL HISTORY

Heart/Circulation	**Medical Problems**	**Other**
☐ Heart Disease/Surgery	☐ Diabetes	☐ Fibromyalgia
☐ High Blood Pressure	☐ Cancer	☐ Arthritis
☐ Numbness in hands/feet	☐ Dizziness	☐ Sleep Problems
	☐ Thyroid problems	☐ Mood disorders
Lungs/Breathing	**Skin Conditions**	**Allergies**
☐ Shortness of breath	☐ Eczema	☐ Food Allergies
☐ Current smoker	☐ Contact Dermatitis	☐ Latex Allergies
☐ Past Smoker	☐ Psoriasis	☐ Seasonal Allergies
☐ Chronic Cough	☐ Other:	☐ Medication Allergies

Do you have any other condition not listed above? _____

PELVIC MEDICAL HISTORY

Have you been diagnosed with prostatitis? ☐ Y ☐ N	Do you have Benign Prostatic Hyperplasia? ☐ Y ☐ N
Do you have difficulty gaining or maintaining penile erection? ☐ Y ☐ N	Do you wake with an erection? ☐ Y ☐ N
Do you suffer from premature ejaculation? ☐ Y ☐ N	Do you have pain after ejaculation? ☐ Y ☐ N
Have you had a recent PSA test? ☐ Y ☐ N	
If you have been diagnosed with prostate cancer, what was your Gleason Score?	
What cancer treatment have you received?	

BLADDER HISTORY

Do you go to the bathroom more than once every 2 hours?	☐ Y ☐ N
Do you have a strong sensation of bladder urgency?	☐ Y ☐ N
Is the urge difficult to ignore?	☐ Y ☐ N
Do you have difficulty getting to the bathroom on time?	☐ Y ☐ N
Do you lose bladder control when you: ☐ Cough ☐ Sneeze ☐ Laugh ☐ Exercise ☐ For no apparent reason	
Do you have frequent bladder infections?	☐ Y ☐ N
Do you wake often at night to void? If yes, how often? ☐ 1 ☐ 2 ☐ 3+	☐ Y ☐ N
Do you use any protective pads? If yes, how many daily? ☐ 1 ☐ 2 ☐ 3+	☐ Y ☐ N
How wet are your pads on an average? ☐ Not wet ☐ Slightly wet ☐ Very wet ☐ Soaked	
Do you feel like you never fully empty your bladder?	☐ Y ☐ N
Urine: ☐ Dark ☐ Smelly ☐ Smoky ☐ traces of blood	
Urine flow: ☐ Weak ☐ Normal ☐ Intermittent ☐ Painful	
Do you have difficulty starting or maintaining your stream?	☐ Y ☐ N
Do you dribble after you void?	☐ Y ☐ N

BLADDER HISTORY

Do you lose bowel control or difficulty controlling gas?	☐ Y ☐ N
Are you prone to constipation?	☐ Y ☐ N
Do you strain to have a bowel movement?	☐ Y ☐ N
Do you have pain with bowel movements?	☐ Y ☐ N
Do you feel like you never fully empty?	☐ Y ☐ N
Do you suffer from: ☐ Hemorrhoids ☐ Irritable bowel ☐ Colitis ☐ Diverticulitis ☐ Other:	

SURGICAL HISTORY

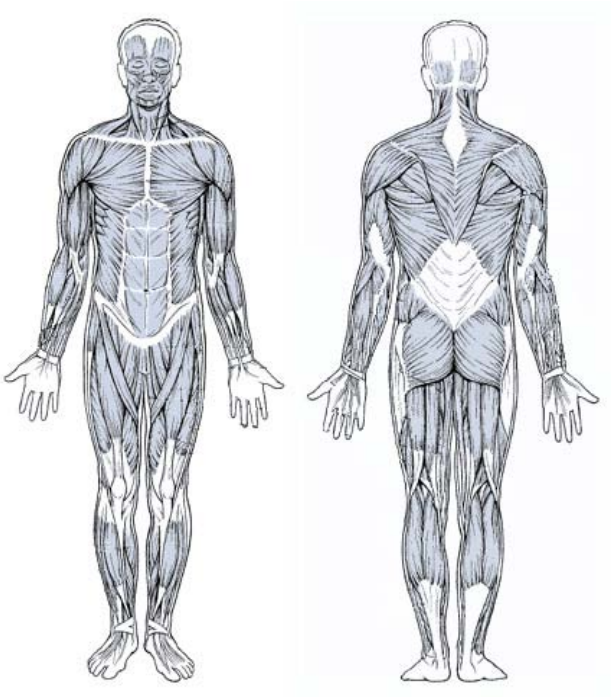
What type of Surgeries have you had?	Year of surgery

LIST OF MEDICATIONS

Name	Reason

FLUID INTAKE	What do you drink every day?
#	Glasses of water
#	Cans of soda ☐decaf ☐ regular
#	Cups of coffee or tea per day ☐decaf ☐ regular
#	Glasses of alcohol (beer, wine or liquor)
#	Other:

Indicate on the diagrams where you experience pain.



Areas of genital pain	
Testicles	☐ Y ☐ N
Tip of penis	☐ Y ☐ N
Scrotum	☐ Y ☐ N

WHAT MAKES YOUR PAIN BETTER?

☐ Heating Pad	☐ Resting in Chair	☐ Abstaining from sex
☐ Ice Pack	☐ Medication	☐ Avoiding tight clothing
☐ Resting in Bed	☐ Cream	☐ Sitz Bath

What started this problem?

_____
_____
_____
_____

_____ _____

Signature of Patient **Date:**