MALE ~ REPRODUCTIVE HEALTH HISTORY

Check and ***Describe*** those symptoms as ***applicable***

Headaches: Migraine______Tension_______Cluster________Low back pain______ Sore heels_______
Varicose Veins ______ Location____
Numbness in legs/feet

Family History of Prostate Disease:_____Type_________________Relationship_______________________________

Family History of Cancer____________________Type_________________Relationship_________________________

History of sexually transmitted disease______________When__________Type_______________________________

Rate your interest in Sex:
High_____________Moderate______________Low______________None___________________

Do you have or ever had difficulty experiencing orgasms____

Have you experienced a history of rape________trauma________incest__If so,-when________________________

Did you undergo counseling for this____

What was this like for you____

Urinary Symptoms (*circle those applicable*)

Painful urination
Bladder/Kidney infections
Frequent Urination
Nocturnal Urination/ Frequency_________
Changes in urinary stream (describe flow, stream, strength of stream)______________________________

When did you first notice these symptoms____

Are they getting better or worse______________Describe____

Erectile Function(*describe as indicated*)

Difficulty obtaining an erection
Difficulty maintaining an erection
Painful ejaculation

Is there a history of back
injury/trauma___________Describe:____

When did you first notice these symptoms____

Are they getting better or
worse______________Describe____

Current Medications or Supplements:____

____

Results of PSA (prostate specific antigen) Test if known_______________ Date done________________________

Results of Sperm count (if applicable and known)________________________Date done______________
AdditionalComments: