MHM MEN'S HEALTH MELBOURNE

SPECIALISTS IN: UROLOGY | FERTILITY | ANDROLOGY

menshealthmelbourne.com.au

Welcome to Men's Health Melbourne. Our goal is to provide you with the best patient care experience.

Thank you for taking the time to fill in this patient questionnaire booklet.

please ensure that you complete all pages that are relevant to you.

Please try be as detailed as possible as it will help the specialist to manage your care.

BEFORE you begin filling in this questionnaire:

- If you have brought ANY documentation with you (referrals, letters, test results) please give these to the front desk reception as the specialist will need to review these PRIOR to the consultation.
- If you have previously sent in any of this documentation, or you expected the documentation to have arrived at our clinic prior to this appointment, please check with the front desk reception that it is in your file.

Please feel free to email us feedback about any aspect of your patient care:
info@menshealthmelbourne.com.au

Regards,

The Team
Men's Health Melbourne

PAST MEDICAL HISTORY

Presenting problem:

Please list the main concern you would like addressed today _____

Have you seen another urologist/specialist for this problem? Y/N

If so, approximately how long ago _____

Medications:

Do you have any Drug allergies? Y/N If Y, please state _____

Do you take any drugs to thin the blood (e.g. aspirin, warfarin, Plavix, Pradaxa etc)? Y/N

Please list your usual medications (dosages not required).

_____

_____

_____

Do you take fish oil? Y/N

Past Urological History:

Have you been previously been diagnosed with a urological problem? Y/N

If Yes – Please tick all relevant:

☐ Kidney (e,g, kidney stones, cancer etc), ☐ Bladder (e.g. UTI, cancer, etc)

☐ Prostate (e.g. enlarged, cancer etc) ☐ Testicle (e.g. infection, cancer etc)

☐ Penis (e.g. erectile dysfunction, Peyronies disease etc)

Please provide details (problem/dates/treatments). Please also note if have had any procedures on any of the above areas.

_____

_____

_____

_____

Have you ever had bleeding in the urine? Y/N

Have you every had any of the following operations:

Circumcision Y/N Date: _____

Vasectomy Y/N Date: _____

Hernia repair Y/N Side: Left/Right/Both Date: _____

Cystoscopy ("camera into the bladder") Y/N Date: _____ Reason: _____

Past procedures:

Please list ANY other operations/procedures you have had and the date of the operation
(even if it is not related to the problem you are seeking treatment for):

_____

_____

_____

_____

Medical conditions:

Please tick if you have been diagnosed with or told you have:

☐ Diabetes type 1/2 ☐ High blood pressure ☐ Bleeding tendency

☐ Deep Vein thrombosis ☐ Breathing/lung problems ☐ HIV/Hepatitis

☐ Cholesterol ☐ Depression/anxiety ☐ Cancer

☐ Problem with anaesthetics ☐ Any Neurological condition – stroke, Parkinson's, spinal problem

☐ Heart condition e.g. Heart attack, arrhythmia (e.g. AF) valve replacement, defibrillator

Please give details about the above condition(s) or list any other conditions:

_____

_____

_____

_____

_____

Family/Social History:

Do you have any significant Family History (e.g. cancer, kidney stones) _____

Do you/have you ever smoked? If Yes – how long for _____ If quit – how long ago _____

Alcohol – How many (if any) standard drinks do you consume per week? _____

Caffeinated beverages – How many (if any) caffeinated beverages do you consume per day? (coffee, tea, Coke, energy drinks) _____

Fluids – in total, how much fluid do you drink per day? _____

Please provide the specialist with any other information relevant to you condition and please write any questions that you would like answered?

_____

_____

_____

_____

If you have ANY urinary voiding symptoms, please complete pages 6 (IPSS)

If you have made an appointment to discuss any issue related to male fertility (incl. fertility checks, vasectomy/ vasectomy reversal, sperm problems), please complete page 8

Thank you once again for taking time to complete this questionnaire.

INTERNATIONAL PROSTATE SYMPTOM SCORE (IPSS)

If you have any problems or symptoms with your urination please fill in this questionnaire prior to seeing the specialist. This will help the specialist in your assessment and personalised management.

Name: _____ Date: _____

	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	YOUR SCORE
Incomplete emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?	0	1	2	3	4	5	
Frequency Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
Urgency Over the last month, how difficult have you found it to postpone urination?	0	1	2	3	4	5	
Weak stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	

	None	1 time	2 times	3 times	4 times	5 times or more	YOUR SCORE
Nocturia How many times (per night) did you typically get up to urinate from the time you went to bed until the time you got up in the morning?	0	1	2	3	4	5	

Total IPSS score	

Total score: 0-7 Mildly symptomatic; 8-19 moderately symptomatic; 20-35 severely symptomatic.

Quality of life due to urinary symptoms	Delighted	Pleased	Mostly satisfied	Mixed – about equally satisfied & dissatis-fied	Mostly dissatis-fied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?	0	1	2	3	4	5	6

MALE FERTILITY QUESTIONS:

Current Partner related questions:

1. How old is your current partner? _____
2. Does she have regular cycles? Y/N
3. Has she had any tests for evaluation of her fertility? Y/N
4. Has she been told that she has a condition that could affect her fertility? Y/N
5. Has your current partner ever had any pregnancies with another man?: Y/N

   If Yes, Please describe the date & outcome of these pregnancies: _____
6. Has she seen an IVF specialist? Y/N

   If Y, please give details of the specialist _____
7. Have she gone through IVF yet? Y/N

   If yes, how many cycles? _____

Vasectomy reversal patients do <u>not</u> need to answer any further questions. All other feritlity related patients, please complete the questionnaire.

8. How many months have you been trying to achieve pregnancy with your current partner? _____
9. Have you ever achieved a pregnancy with your partner in the past? Y/N

   If yes, please give date & outcome of pregnancies: _____
10. Have you ever achieved a pregnancy with another partner? Y/N

    If Yes, please give the date & outcome of these pregnancies _____
11. Have you ever had a semen analysis? Y/N

    If Y, please give dates (approx.) _____
12. Have you ever been told you have a sperm problem? Y/N
13. Have you had any blood tests/ultrasounds to investigate your infertility? Y/N
14. Have you ever had an STD? Y/N
15. Have you had any major childhood illnesses? Y/N
16. Have you had any problems with you testicles in the past? Y/N

    ☐ Trauma ☐ Undescended testicles as a child ☐ Surgery
17. Do you have any erection/libido problems? Y/N