

PELVIC PAIN INFORMATION FORM - MEN

Name \_\_\_\_\_ Date \_\_\_\_\_

What was the approximate date the problem began? \_\_\_\_\_

Did this condition begin suddenly or gradually (please circle one)

My problem is getting better getting worse about the same (please circle one)

Please describe your symptoms: \_\_\_\_\_

Please rate your pain or symptoms on a scale of 0 to 10:

today \_\_\_\_\_

1 - mild and doesn't interfere with activities  
5 - moderate with noticeable discomfort

at best \_\_\_\_\_

7 - moderate to severe - interferes with  
activities, but not disabling

at worst \_\_\_\_\_

10 - severely disabling, unable to function

Are your symptoms (circle one) constant intermittent?

Do your symptoms change during the day? \_\_\_\_\_ How? \_\_\_\_\_

Do your symptoms interfere with sleep?

What makes the symptoms worse? \_\_\_\_\_

What makes the symptoms better? \_\_\_\_\_

Is your condition aggravated by (circle any) sitting standing walking lying down?

Please list **ANY** other medical conditions you have (e.g. high blood pressure, heart problems, diabetes) \_\_\_\_\_

Do you have headaches? Yes / No      Jaw pain? Yes / No      Back pain? Yes / No

Are your stools normal ? Yes/No

Do you have (circle one) constipation loose stools both?

Do you have the feeling you have to urinate frequently? Yes / No

How many times per night do you get up to urinate? \_\_\_\_\_

Do your symptoms interfere with sexual function?

Are you now sexually active? Yes / No

