

Men's Health Boston Questionnaire

Date _____ Name _____

Date of Birth _____ Name of partner _____

Address: _____

Home Phone # _____ Work Phone# _____

Can a confidential message be left on an answering machine? Y or N

Name of Regular Referring Doctor: _____

Name of Primary Care Doctor if different from referring: _____

Primary Care Physician's telephone number: _____

Occupation _____

Briefly describe your symptoms or problems: _____

List Medications
(including herbals/vitamins)

List any and all surgeries and when?
(vasectomy, varicocele surgery, hernia, etc)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Which medications/substances (including Latex) are you allergic to and reaction?

Have you had any of the following (please circle). If yes, when?

Heart Disease/Heart Attack	Y/N	Chemical Exposure	Y/N
High Blood Pressure	Y/N	Radiation/Chemotherapy	Y/N
Diabetes	Y/N	Kidney Stones	Y/N
Bleeding Problems	Y/N	Blood in Urine	Y/N
Transfusions	Y/N	Low Testosterone	Y/N
Sexually Transmitted Diseases	Y/N	Undescended Testicles	Y/N
Urinary Tract Infections	Y/N	Prostate Cancer/Surgery	Y/N
Epididymitis	Y/N	Sleep Apnea	Y/N
Prostatitis	Y/N	Other problems?	_____

Any family history of prostate cancer? Y/N If yes, whom? _____

How many children to you have? _____ Ages/Gender? _____

Any Family History of infertility? _____

How much do you smoke? _____ How much alcohol do you drink? _____

Do you use any recreational drugs? Y/N If yes, which? _____

How often do you awake at night to urinate? _____ times

Is your urine stream weak? Y/N Do you feel you empty well? Y/N