New Male Patient Questionnaire

Name:________________________________ DOB:__________________ Age:__________

Height:_____________ Weight:_____________

Last Colonoscopy:___________ Last Prostate Exam:____________

Personal history of prostate cancer? Yes No

Family history of prostate cancer? Yes No

Previous hormone replacement:____

Please mark which of the following symptoms you have experienced in the last two weeks on a scale of 0-5, where 0=none and 5=very severe/daily.

Physical exhaustion/ fatigue

0 1 2 3 4 5

Depressed mood

0 1 2 3 4 5

Anxiety

0 1 2 3 4 5

Irritability

0 1 2 3 4 5

Increased need for sleep

0 1 2 3 4 5

Sweating (night sweats or sweating episodes)

0 1 2 3 4 5

Weight Gain/ Difficulty Losing Weight

0 1 2 3 4 5

Hair Loss/ Thinning Hair

0 1 2 3 4 5

Memory issues

0 1 2 3 4 5

Difficulty Concentrating/Thinking/Reasoning

0 1 2 3 4 5

Joint/Muscle Pain

0 1 2 3 4 5

Erectile Changes

0 1 2 3 4 5

Sexual Difficulty (change in desire/performance)

0 1 2 3 4 5

Infrequent/ Absent Ejaculations

0 1 2 3 4 5

Sleep Problems

0 1 2 3 4 5

Bladder Issues (incontinence, urgency, frequency)

0 1 2 3 4 5