Male Questionnaire

Name **Date**

INSTRUCTIONS: Please circle the number which best describes the frequency or severity of your complaints. Leave the question blank if it does not apply to you.
0 = RARELY OR NEVER EXPERIENCE SYMPTOM 1 = MILD 2 = MODERATE 3 = SEVERE

PART 1: For Males Only

Section A:

1	Increased urinary frequency	0 1 2 3
2	Need to urinate during the night	0 1 2 3
3	Reduced urine flow with increased strain	0 1 2 3
4	Difficulty in urinating or stopping urine flow	0 1 2 3
5	Pain or burning during urination	0 1 2 3
6	Discharge from penis after bowel movements	0 1 2 3
7	Blood or pus in urine	0 1 2 3
8	Back pain or leg pain	0 1 2 3
9	Fever/chills	0 1 2 3
10	Impotence (difficult to maintain an erection)	0 1 2 3
11	Prostate trouble (Press 0 for NO, 1 for YES)	NO YES
12	Lost or diminished sex drive (Press 0 for NO, 1 for YES)	NO YES

Section B:

1	Inability to achieve or maintain an erection	0 1 2 3
2	Premature ejaculation	0 1 2 3
3	Inability to ejaculate	0 1 2 3
4	Inability to impregnate a woman (Press 0 for NO, 1 for YES)	NO YES
5	Is your sperm count low? (Press 0 for NO, 1 for YES)	NO YES
6	Low or diminished sex drive (Press 0 for NO, 1 for YES)	NO YES
7	Currently taking medication (anti-hypertensives, tranquilizers or Tagamet) (Press 0 for NO, 1 for YES)	NO YES

Section C:

1	Unusual discharge from penis	0 1 2 3
2	Itchy genitals	0 1 2 3
3	Swelling or pain in genital area	0 1 2 3
4	Recent changes in urination (frequency,etc.)	0 1 2 3
5	Burning in the genital area	0 1 2 3
6	Bumps or blisters on the genitals	0 1 2 3
7	Visible warts on genitals	0 1 2 3
8	Diagnosed with sexually transmitted disease (herpes, gonorrhea, warts, etc.) (Press 0 for NO, 1 for YES)	NO YES