Pelvis Questionnaire - Male

If you’re coming to our center for this test, print this page, fill out the form and bring it in with you on the day of your appointment.

FIRST NAME

LAST NAME

AGE WEIGHT DATE

WHAT WAS YOUR CHIEF COMPLAINT WHEN YOU VISITED YOUR DOCTOR?

WHICH AREA IS AFFECTED? ☐ LEFT ☐ CENTRAL ☐ RIGHT

ANY HISTORY OF CANCER? ☐ YES ☐ NO

IF YES, WHERE?

HOW LONG HAVE YOU HAD THIS PROBLEM?

ANY SURGERY OF THE PELVIS? ☐ YES ☐ NO

IF YES, WHEN AND WHAT WAS DONE?

ANY PROSTATE SURGERY? YES NO
ARE YOU RECEIVING HORMONAL THERAPY?  □ YES  □ NO

ANY OTHER MEDICAL CONDITIONS?  □ YES  □ NO

DESCRIBE YOUR GENERAL HEALTH?