The Murray Koffler Urologic Wellness Centre

60 Murray Street, 6th floor, Toronto, ON, M5T 3L9

You have been referred to the Multi-Disciplinary Scrotal Pain Clinic. We would ask that you please fill in the following questionnaire as completely and accurately as possible before you see the doctor. All provided information will remain confidential. It will be released only with your written permission.

Today's Date: ____/____/_____ (DD/MM/YYYY) MSID#: _____

Name: _____, _____ (Last Name) (First Name) DOB: ____/____/_____ (DD/MM/YYYY)

Referring MD: _____

Occupation: _____ Number of years at current job: _____

Previous occupation: _____

Do you have any allergic reactions to medications? Y/N

Which medications and what type of reaction? _____

Pain/Discomfort Location and history:

When did your scrotal pain/discomfort begin?_____ (year)

Was there something which started the pain? Y/N

Vasectomy [ ] Hernia repair [ ] Injury [ ] Infection [ ]

Other_____

Since the pain began has the pain/discomfort generally become

better [ ], same [ ] or worse [ ]

What can you do to improve the pain?

Standing [ ], Lying [ ], other _____

What makes the pain worse?

Tight clothing [ ], Sitting [ ], Movement [ ], Sex [ ], Ejaculation [ ]

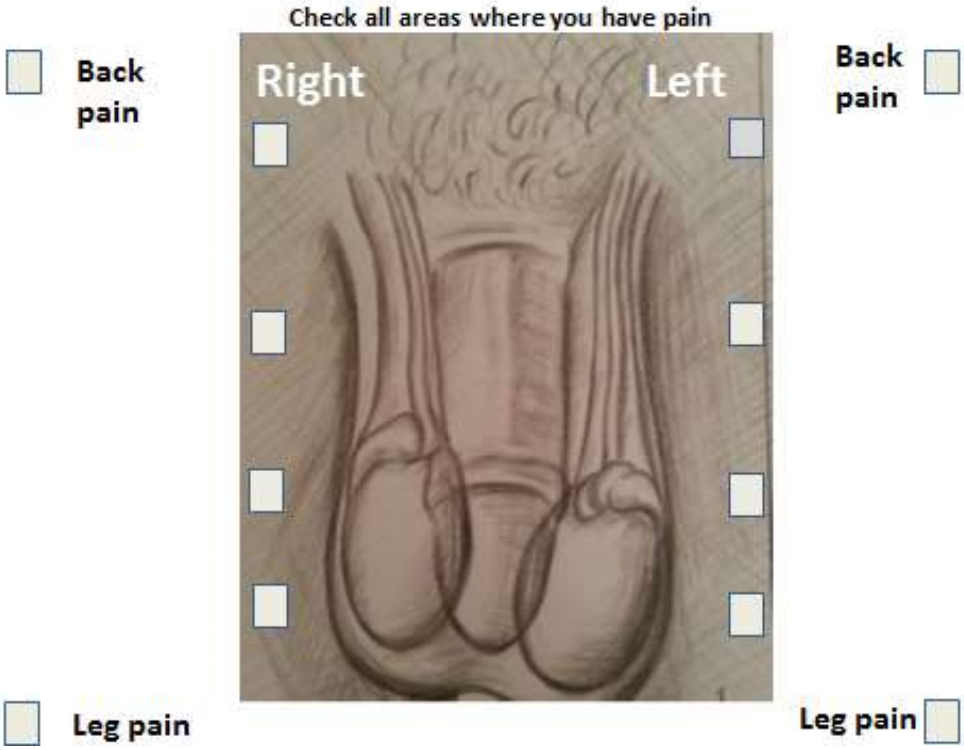
Other_____

How would you describe the pain/discomfort?

Sharp [ ], Shooting [ ], Pressure [ ], Dull [ ], Achy [ ], Electric [ ], Numb/Tingling [ ]

Other_____

Areas of pain/discomfort:



Present Pain levels and frequency of pain: *(circle the most accurate answer)*

When you have pain, how bad was your AVERAGE pain in the last month?	**1 2 3 4 5 6 7 8 9 10** No pain Pain as bad as you can imagine			
How bad was your MOST SEVERE (WORST) pain in last month?	**1 2 3 4 5 6 7 8 9 10** No pain Pain as bad as you can imagine			
What percentage of the time did you have the MOST SEVERE pain in the past month? (YOUR BEST GUESS)	**10% 20% 40% 60% 80% 100%**			
How much have your symptoms kept you from doing the **kinds of things you would usually do**, over the last month?	None	Only a little	Some	A lot
How much have your symptoms kept you from **performing your normal work**?	None	Only a little	Some	A lot
How much have your symptoms kept you from **normal sexual activity?**	None	Only a little	Some	A lot
How much did you **think about your symptoms**, over the last month?	None	Only a little	Some	A lot

Describe the impact of the scrotal pain on your life

_____

_____

Describe what changes you have made in your life because of the scrotal pain

_____

_____

If you were to spend the rest of your life with your symptoms just the way they have been during the last month, how would you feel about that?

1 Delighted
2 Pleased
3 Mostly satisfied
4 Mixed (about equally satisfied and dissatisfied)
5 Mostly dissatisfied
6 Unhappy
7 Terrible

What therapies have been used to treat the scrotal pain/discomfort?

What medications have been used to treat the scrotal pain/discomfort?

[ ] Over the counter pain medications like Tylenol, Ibuprofen, Motrin
[ ] Prescribed pain medications like codeine, oxycodone, fentanyl, morphine
[ ] Antibiotics
[ ] Anti-inflammatories like ibuprofen, celebrex, vioxx
[ ] Medications for nerve pain like lyrica, gabapentin, carbamazepine
[ ] Anti-depressants like elavil, tofranil, imipramine
[ ] Other_____

Surgery/procedures to treat scrotal pain/discomfort

Vasovasostomy (Vasectomy Reversal)	L/R/Both Sides/No	Date: _____
Varicocelectomy	L/R/Both Sides/No	Date: _____
Removal of Epididymis	L/R/Both Sides/No	Date: _____
Removal of Testicle	L/R/Both Sides/No	Date: _____
Nerve blocks	L/R/Both Sides/No	Date: _____
Removal of Nerves to the testicle	L/R/Both Sides/No	Date: _____

Other _____/_____

Medical History

Height _____Feet_____inches Weight_____ Lbs

Diabetic Y/N

Do you have any other chronic pain issues? Y/N

Bowel/stomach Y/N Fibromyalgia Y/N Headaches/Migraines Y/N

Infections *(Please circle Y or N)*

Gonorrhea	Y/N	Genital warts	Y/N	Chlamydia	Y/N	Syphilis	Y/N
Herpes	Y/N						
Bladder	Y/N	Prostate	Y/N	Testis	Y/N	Penis	Y/N
SHINGLES	Y/N						

Other _____

Past Surgical History *(Please circle Y or N, and fill in the appropriate blanks if Yes)*

Hernia:	L/R/Both Sides/No	Date: _____/_____
Undescended Testes	L/R/Both Sides/No	Date: _____/_____
Vasectomy	Yes / No	Date: _____
Abdominal/Pelvic Surgery	Yes / No	Date: _____

Other _____/_____

Lifestyle

Smoking		Y/N	<1 / 1 / 2 / ≥2 pack(s) per day
Alcohol		Y/N	<1 / 1 / 2 / 3 / ≥4 drinks/per day
Marijuana	Used in last six months?	Y/N	
Cocaine	Used in last six months?	Y/N	
Other drugs	Used in last six months?	Y/N	Type _____

Androgen (Male Hormone) Deficiency and Sexual Dysfunction Questionnaire

1. Do you have a decrease in libido (sex drive)?	Yes	No
2. Do you have a lack of energy?	Yes	No
3. Do you have a decrease in strength and/or endurance?	Yes	No
4. Have you lost height?	Yes	No
5. Have you noticed a decreased enjoyment of life?	Yes	No
6. Are you sad and/or grumpy?	Yes	No
7. Are your erections less strong?	Yes	No
8. Have you noted a recent deterioration in your ability to play sports?	Yes	No
9. Are you falling asleep after dinner?	Yes	No
10. Has there been a recent deterioration in your work performance?	Yes	No

Circle the most correct answer

During the past month, have you **often** been bothered by feeling down, depressed, or hopeless?	Not at all	Several days	More than half the days	Nearly every day
During the past month, have you **often** been bothered by little interest or pleasure in doing things?	Not at all	Several days	More than half the days	Nearly every day