



Mayan Abdominal Massage

MALE REPRODUCTIVE HEALTH HISTORY

Check conditions, as applicable:

Headaches: Tension Migraine Cluster

Low back pain

Sore heels

Varicose veins Location

Numbness in legs/feet

Family history of prostate disease Type

Which relative?

Family history of cancer Type

Which relative(s)?

Have you ever had a sexually transmitted disease?

If yes, when and what type?

Rate your interest in sex:

High Moderate Low None

Do you now have or have you ever had difficulty experiencing orgasm?

Have you experienced rape? Sexual trauma? Incest?

If so, when?

Did you receive counseling?

Urinary symptoms (check any that apply):

Painful urination Bladder/kidney infections Frequent urination

Urination at night – Frequency

Changes in urinary stream (describe flow, stream, strength of stream)

When did you first notice these symptoms?

Are they getting better or worse? Describe

Erectile function (check any that apply):

Difficulty obtaining an erection Difficulty maintaining an erection Painful ejaculation

Have you ever had a back injury? Describe:

When did you first notice these symptoms?

Are they getting better or worse? Describe:

Current medications or supplements:

Have you had a PSA (prostate-specific antigen) test? If so, date:

Result:

Sperm count (if applicable and known: Date done:

Additional comments: