

Male Genitalia

Name: _____

Date: _____

Age: _____

History

Review of history related to male genitalia, hernia, and sexual function:

Children Born: _____ Living: _____ Stepchildren: _____

YES/NO

If YES, provide details:

Genitals

- | | | | |
|--------------------------|--------------------------|--------------------------|-------|
| <input type="checkbox"/> | <input type="checkbox"/> | History of problems | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | STD | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Genital burning, itching | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Penis discharge | _____ |

Hernia

- | | | | |
|--------------------------|--------------------------|---------------------------------------|-------|
| <input type="checkbox"/> | <input type="checkbox"/> | History of hernia (inguinal, scrotal) | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Bulge or fullness in inguinal area | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Groin-area pain or discomfort | _____ |

Urinary — Prostate

- | | | | |
|--------------------------|--------------------------|----------------------------------|-------|
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney or urinary disease | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent urination | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficult or painful urination | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary incontinence | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty starting urination | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Dribbling following urination | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Feeling bladder not emptied | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hematuria or foul-smelling urine | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer history | _____ |

Scrotum

- | | | | |
|--------------------------|--------------------------|----------|-------|
| <input type="checkbox"/> | <input type="checkbox"/> | Hernia | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling | _____ |

- Fertility _____
- TSE (Performs? Able to do?) _____
- Lumps or lesions _____

Sexual Function

- Sexually active _____
- Number of partners _____
- Gender of partners _____
- Difficulty maintaining erection _____
- Satisfied with performance _____
- Sexual protection _____
- Infertility problems _____
- Family, life, job stress _____
- Alcohol use _____

Medical problems in other systems related to reproductive (diabetes, spinal cord injury, cardiovascular disease, neurological disease, handicapping conditions): _____

Focused symptom analysis of current problem:

- Reason for visit:** _____
- _____
- Character:** _____
- Onset:** _____
- Duration:** _____
- Location:** _____
- Severity:** _____
- Associated problems:** _____
- Efforts to treat:** _____

Current medications: _____

Family history of problems of the reproductive system: _____

Physical Assessment

Protect the nurse with gloves and an assistant of the same sex as the client.

Inspection

General characteristics (genital skin color, swelling, redness, lesions: hair distribution, infestations, hygiene): _____

Penis (position, color, symmetry, contour, scars, venous pattern, pulsations, smegma, external meatus of urethra, urethral discharge): _____

Scrotum (skin color, texture, symmetry, swelling, lesions, infestation; transilluminate if swollen):

Lymph (redness, swelling): _____

Palpation

Femoral arteries (pulse rate and quality, bilateral comparison): _____

Inguinal lymph nodes (presence of lymph nodes, tenderness, enlargement, bilateral comparison):

Penis (tenderness, tissue consistency, retraction of foreskin, milk urethra — assess discharge):

Scrotum (testes bilateral, swelling, nodules, tenderness, mass(es)): _____

Inguinal or femoral hernia (presence of hernia or bulge — bilateral assessment): _____

See anus and rectum, next page.

Analysis:

Anus, Rectum, and Prostate

History

Review of history related to anus, rectum, and prostate:

YES/NO	If YES, provide details:
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Stools

- | | | | |
|--------------------------|--------------------------|---------------------------------|-------|
| <input type="checkbox"/> | <input type="checkbox"/> | Change in bowel habits | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty with bowel movements | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Flatulence | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Fecal incontinence | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Routine use of laxatives | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Routine use of other bowel meds | _____ |

Stool characteristics

Frequency of bowel movements _____
Color and consistency of stool _____

Anus and Rectum

Anal or rectal bleeding _____
Color of blood bright red black, tarry mixed
Associated with bowel movement yes no

Itching or pain _____
 Hemorrhoids _____
 Rectal polyps _____
 Colonoscopy _____

Focused symptom analysis of current problem:

Reason for visit: _____

Character: _____

Onset: _____

Duration: _____

Location: _____

Severity: _____

Associated problems: _____

Efforts to treat: _____

Physical Assessment

Inspection

Rectum (skin characteristics, hemorrhoids, lesions, skin tags, inflammation, drainage, prolapse):

Palpation

Rectum (sphincter tone; internal or external hemorrhoids; rectal tone; presence of stool, pain or tenderness; posterior rectal wall characteristics): _____
