New Patient Survey For Patients Visiting Alliance Urology for Scrotal Pain

Clinic - (336)274-1114

Name: _____Date of Birth:_____

1) How long have you been having pain in your scrotum? (Please write a number and circle years or months)

__ years / months

2) Is the pain on the: Left / Right / Both (Please circle one)

3) Have you tried any interventions to help improve your pain? (ex. oral medications, Ibufprofen, Tylenol, Ice packs, supportive underwear...)

Yes / No

If yes, please list: _____

4) Were these treatments effective when you first tried them? Circle yes or no. Please leave blank if you answered 'no' to the previous question.

Yes / No

5) Does the pain radiate or spread anywhere when it occurs (groin, back, other testicle…)?

Yes / No Explain: _____

6) If you had to rank the severity of your pain at its WORST from 0-10 with 0 being no pain and 10 being the worst pain you've ever experienced, what ranking would you give?

___ (out of 10)

7) Does the pain prevent you from doing things you enjoy?

Yes / No Explain: _____

8) Have you ever had any surgeries or procedures on your groin, penis, or testicles (vasectomy, hernia repair, hydrocele..)?

Yes / No Explain: _____

9) Have you ever had any infections involving your groin, penis, or testicles (epididymitis, orchitis, STDs - gonorrhea, chlamydia..)?

Yes / No Explain: _____

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