MALE HISTORY

GENERAL INFORMATION

Name _____ Today's Date _____
Address _____ City _____ State _____ Zip _____
Age _____ DOB _____ Height _____ Weight _____ Phone _____ Email _____

SPECIFIC COMPLAINTS/CONCERNS/SYMPTOMS

Please list your chief symptoms in order of decreasing severity, starting with the worst one. Please note when they started, how often they occur, and their severity.

Problem	When did it start?	How often?	How severe is it?
1. e.g. Headaches	June 2009	3 times per week	mild/moderate/severe
2.			
3.			
4.			
5.			
6.			
7.			

GENERAL SYMPTOMS

Symptom	Mild	Moderate	Severe	Comments
Body/joint aches				
Weight gain				
Weight loss				
Elevated blood pressure				
Elevated cholesterol				
Digestive problems				
Head hair loss				
Dry or thinning skin				
Constant hunger				
Sweet cravings				
Caffeine cravings				
Salt cravings				
Anger or aggression				
Irritability				
Low mood/depression				
Concentration problems				
Foggy thinking				
Increased fatigue				
Lowered labido				
Erectile dysfunction				
Frequent need to urinate				
Pain with urination				
Bone loss/osteoporosis				
Low blood sugar				
Other				

MALE HISTORY 2

MEDICATIONS AND SUPPLEMENTS

Please list all medications that you are taking or have taken in the last month, including prescription drugs, non-prescription drugs, antibiotics, vitamins, minerals and nutritional supplements: (use back if necessary)

Medication or Supplement	Dosage	Any Side Effects?

ALLERGIES

Medication/Supplement/Food/Animal/Environmental	Reaction

IMMUNIZATION HISTORY

Have you received any vaccinations in the last 5 years? Yes No If yes, please list:

_____

_____

_____

_____

DENTAL HISTORY

Do you currently have any amalgam, silver, metal, and/or gold fillings? Yes No
If yes, which kind: _____ How many? _____
How long have you had these fillings? _____
If you don't have any fillings have you had any removed in the last 12 months? Yes No
Have you had any other dental work done in the last 12 months? Yes No What? _____

SLEEP/REST

Average number of hours you sleep >10 8 – 10 6 – 8 <6
Do you have trouble falling asleep? Yes No
Do you get a second wind at night? Yes No
Do you have problems with insomnia? Yes No
Do you feel rested upon awakening? Yes No
Do you snore? Yes No
Do you use sleeping aids? Yes No What kind? _____ How often? _____

MALE HISTORY 3

LIFESTYLE INDICATORS

Tobacco Intake

Currently using tobacco: No Yes Cigarettes Smokeless Cigar Pipe Patch/Gum Snuff/Chew
How long? _____ How often? _____ How much? _____
Previous smoking? How many years? _____ Packs per day: _____ How long ago: _____
Are you exposed to second hand smoke? If yes, please explain: _____

Alcohol Intake

How many drinks currently per week? (1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits)
None _____ 1-3 _____ 4-6 _____ 7-10 _____ >10 _____
Previous alcohol intake? Yes ____ (Mild _____ Moderate _____ High _____)

Caffeine Intake

How many cups of coffee per day? None _____ 1-3 _____ 4-6 _____ 7-10 _____
How many cans of soda per day? None _____ 1-3 _____ 4-6 _____ 7-10 _____
Is the soda you drink, diet soda? Yes No

EXERCISE

How often do you exercise? Once a month or less Once a week or less Weekly 2x 3x 4x+
Do you: Walk Run Lift Weights Yoga Golf or other sports Martial Arts Other _____
Average length of your workout _____

MISCELLANEOUS

Have you had a vasectomy? Yes No When? _____
Have you had a reverse vasectomy? Yes No When? _____
Have you experienced symptoms related to the vasectomy? Yes No Explain _____
_____
Do you have a history of prostate problems? Yes No Explain _____
_____
Date of last Prostate Exam _____
Most recent PSA results _____ Date _____

Does your occupation or your hobbies affect your health? (e.g. shift work, lifting, jumping, sparring, etc.)
_____

Is there any other information that you feel would be important for the Doctor to know?_____
_____
_____
_____

NOTES:

Healthy Happy You