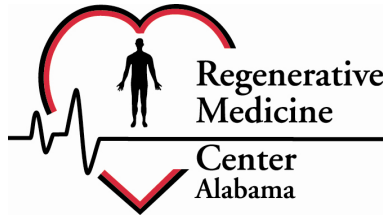


Larry D. Brock, M.D.
5901 Airport Blvd., Suite E
Mobile, AL 36609



Office: (251) 342-0505
Fax: (251) 342-0360

Health History Questionnaire for Men

(All questions contained in this questionnaire will be kept strictly confidential)

Name: <i>(Last, First, M.I.)</i>	DOB Age
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorce <input type="checkbox"/> Widowed	
Occupation:	Height: Weight:

Personal Health History

Reason for Office Visit _____

List current health problems for which you are being treated: _____

What type of therapies have you tried for these problems or to improve your health over-all:
 diet modification fasting vitamins/minerals herbs homeopathy chiropractic

Allergies to Medication:	
Name of Drug	Reaction
_____	_____
_____	_____
_____	_____

Current Medications:			
Name of Medicine	Strength	Frequency Taken	Prescribing Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Personal Medical History

- | | | |
|--|--|---|
| <input type="checkbox"/> Arthritis
<input type="checkbox"/> Allergies/hay fever
<input type="checkbox"/> Asthma
<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Alzheimer's disease
<input type="checkbox"/> Autoimmune disease
<input type="checkbox"/> Blood pressure problems
<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Cancer
<input type="checkbox"/> Chronic fatigue syndrome
<input type="checkbox"/> Carpal tunnel syndrome
<input type="checkbox"/> Cholesterol, elevated
<input type="checkbox"/> Circulatory problems
<input type="checkbox"/> Colitis
<input type="checkbox"/> Dental problems
<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Diverticular disease
<input type="checkbox"/> Drug addiction | <input type="checkbox"/> Eating disorder
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Emphysema
<input type="checkbox"/> Eyes, ears, nose, throat problems
<input type="checkbox"/> Environmental sensitivities
<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Food intolerance
<input type="checkbox"/> Gastroesophageal reflux disease
<input type="checkbox"/> Genetic disorder
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Gout
<input type="checkbox"/> Heart disease
<input type="checkbox"/> Infection, chronic
<input type="checkbox"/> Inflammatory bowel disease
<input type="checkbox"/> Irritable bowel syndrome
<input type="checkbox"/> Kidney or bladder disease
<input type="checkbox"/> Learning disabilities
<input type="checkbox"/> Liver or gallbladder disease
(stones) | <input type="checkbox"/> Mental illness
<input type="checkbox"/> Mental retardation
<input type="checkbox"/> Migraine headaches
<input type="checkbox"/> Neurological problems
<input type="checkbox"/> (Parkinson's, paralysis)
<input type="checkbox"/> Obesity
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Sexually transmitted disease
<input type="checkbox"/> Seasonal affective disorder
<input type="checkbox"/> Skin problems
<input type="checkbox"/> Sinus problems
<input type="checkbox"/> Stroke
<input type="checkbox"/> Thyroid trouble
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Ulcer
<input type="checkbox"/> Urinary tract infection
<input type="checkbox"/> Varicose veins
Other _____ |
|--|--|---|

Men's Health History

- Do you usually get up to urinate during the night? Yes No
 If yes, # of times: _____
- Do you feel pain or burning with urination? Yes No
- Have ever had a sexually transmitted disease..... Yes No
 If so, date: _____
- Any blood in your urine? Yes No
- Do you feel burning discharge from penis? Yes No
- Has the force of your urination decreased? Yes No
- Have you had any kidney, bladder, or prostate infections within the last 12 months?.. Yes No
- Do you have any problems emptying your bladder completely? Yes No
- Any difficulty with erection or ejaculation? Yes No
- Date of last ejaculation: _____
- Any testicle pain or swelling? Yes No

Date of last prostate and rectal exam: _____

Date of last colonoscopy: _____

Have you had a vasectomy? Yes No Date: _____

Diagnostic Procedures:		Normal
PSA	Date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prostate Exam	Date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Colonoscopy	Date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bone Density	Date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Scan (coronary calcium score)	Date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other _____		

Surgeries		
Year	Type	Hospital

Other Hospitalizations:		
Year	Problem	Hospital

Have you ever had a blood transfusion? Yes No Date: _____

Childhood Illnesses:	<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Rubella	<input type="checkbox"/> Chicken Pox
	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Polio		

Health Habits and Personal Safety

Exercise:	<input type="checkbox"/> Sedentary (No exercise)	<input type="checkbox"/> Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)
	<input type="checkbox"/> Occasional Vigorous Exercise (i.e., work or recreation less than 4x/week for 30 min.)	<input type="checkbox"/> Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)
Do you work out at a Gym?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you participate in other sports?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Body Composition	Do you consider yourself: <input type="checkbox"/> underweight <input type="checkbox"/> overweight <input type="checkbox"/> just right Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you dieting? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you on a physician prescribed medical diet? <input type="checkbox"/> Yes <input type="checkbox"/> No # of meals you eat in an average day? _____ Salt Intake: <input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low Fat Intake: <input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low
Caffeine:	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola # of Cups/Cans per day: _____
Alcohol:	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what kind? _____ How many drinks per week? _____ Are you concerned about the amount you drink? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you considered stopping? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever experienced blackouts? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you prone to "binge" drinking? <input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco:	Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Cigarettes-Pks/day ____ <input type="checkbox"/> Chew-#/day ____ <input type="checkbox"/> Pipe-#/day ____ <input type="checkbox"/> Cigars-#/day <input type="checkbox"/> # of Years ____ or <input type="checkbox"/> Year Quit ____
Drugs:	Do you currently use recreational or street drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever given yourself street drugs with a needle? <input type="checkbox"/> Yes <input type="checkbox"/> No

What are you current health goals?

1. _____ 3. _____
 2. _____ 4. _____

Family Health History							
	Age	Age at Death	Significant Health Problems or Cause of Death		Age	Age at Death	Significant Health Problems or Cause of Death
Father	_____	_____	_____	Children	<input type="checkbox"/> M	_____	_____
Mother	_____	_____	_____		<input type="checkbox"/> F	_____	_____
Brothers and Sisters	<input type="checkbox"/> M	_____	_____	<input type="checkbox"/> M	_____	_____	_____
	<input type="checkbox"/> F	_____	_____	<input type="checkbox"/> F	_____	_____	_____
	<input type="checkbox"/> M	_____	_____	Grandparents (Mother's Side)	Male	_____	_____
	<input type="checkbox"/> F	_____	_____		Female	_____	_____
	<input type="checkbox"/> M	_____	_____	Grandparents (Father's Side)	Male	_____	_____
	<input type="checkbox"/> F	_____	_____		Female	_____	_____

Parents and Siblings

- | | | |
|--|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Neurological disorders
(Parkinson's, paralysis) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Genetic disorder | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Infertility | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Learning disabilities | Other _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental illness | |
| <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Mental retardation | |

List Primary Care Physician:

Name:

Group:

Address:

Phone:

Fax:

List Men's Specialist:

Name:

Group:

Address:

Phone:

Fax:

Diagnosis:

1. _____ 3. _____

2. _____ 4. _____