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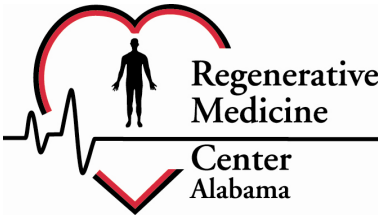

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Health History Questionnaire for Men

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

Name: *(Last, First, M.I.)*	**DOB** **Age**
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorce ☐ 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

- □ Arthritis
- □ Allergies/hay fever
- □ Asthma
- □ Alcoholism
- □ Alzheimer's disease
- □ Autoimmune disease
- □ Blood pressure problems
- □ Bronchitis
- □ Cancer
- □ Chronic fatigue syndrome
- □ Carpal tunnel syndrome
- □ Cholesterol, elevated
- □ Circulatory problems
- □ Colitis
- □ Dental problems
- □ Depression
- □ Diabetes
- □ Diverticular disease
- □ Drug addiction
- □ Eating disorder
- □ Epilepsy
- □ Emphysema
- □ Eyes, ears, nose, throat problems
- □ Environmental sensitivities
- □ Fibromyalgia
- □ Food intolerance
- □ Gastroesophageal reflux disease
- □ Genetic disorder
- □ Glaucoma
- □ Gout
- □ Heart disease
- □ Infection, chronic
- □ Inflammatory bowel disease
- □ Irritable bowel syndrome
- □ Kidney or bladder disease
- □ Learning disabilities
- □ Liver or gallbladder disease (stones)
- □ Mental illness
- □ Mental retardation
- □ Migraine headaches
- □ Neurological problems
- □ (Parkinson's, paralysis)
- □ Obesity
- □ Osteoporosis
- □ Pneumonia
- □ Sexually transmitted disease
- □ Seasonal affective disorder
- □ Skin problems
- □ Sinus problems
- □ Stroke
- □ Thyroid trouble
- □ Tuberculosis
- □ Ulcer
- □ Urinary tract infection
- □ 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: _____	□ Yes	□ No
Prostate Exam	Date: _____	□ Yes	□ No
Colonoscopy	Date: _____	□ Yes	□ No
Bone Density	Date: _____	□ Yes	□ No
Cardiac Scan (coronary calcium score)	Date: _____	□ Yes	□ No
Other _____			

Surgeries

Year	Type	Hospital

Other Hospitalizations:

Year	Problem	Hospital

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

Childhood Illnesses: □ Measles □ Mumps □ Rubella □ Chicken Pox □ Rheumatic Fever □ Polio

Health Habits and Personal Safety

Exercise:

□ Sedentary (No exercise) □ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)

□ Occasional Vigorous Exercise (i.e., work or recreation less than 4x/week for 30 min.)

□ Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)

Do you work out at a Gym? □ Yes □ No

Do you participate in other sports? □ Yes □ No

Body Composition	Do you consider yourself: □underweight □ overweight □ just right Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? □ Yes □ No Are you dieting? □ Yes □ No If yes, are you on a physician prescribed medical diet? □ Yes □ No # of meals you eat in an average day?_____ Salt Intake: □ Hi □ Med □ Low Fat Intake: □ Hi □ Med □ Low
Caffeine:	□ None □ Coffee □ Tea □ Cola # of Cups/Cans per day: _____
Alcohol:	Do you drink alcohol? □ Yes □ No If yes, what kind? _____How many drinks per week? _____ Are you concerned about the amount you drink? □ Yes □ No Have you considered stopping? □ Yes □ No Have you ever experienced blackouts? □ Yes □ No Are you prone to "binge" drinking? □ Yes □ No
Tobacco:	Do you use tobacco? □ Yes □ No □ Cigarettes-Pks/day ____ □ Chew-#/day ___ □Pipe-#/day____ □ Cigars-#/day □ # of Years ____ or □ Year Quit ____
Drugs:	Do you currently use recreational or street drugs? □ Yes □ No Have you ever given yourself street drugs with a needle? □ Yes □ 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**	□ M □ F		
Mother					□ M □ F		
Brothers and Sisters	□ M □ F				□ M □ F		
	□ M □ F				Male		
	□ M □ F			**Grandparents (Mother's Side)**	Female		
	□ M □ F			**Grandparents (Father's Side)**	Male		
					Female		

Parents and Siblings

- ☐ Arthritis
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Infertility
- ☐ Learning disabilities
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Neurological disorders (Parkinson's, paralysis)
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Suicide

Other _____

List Primary Care Physician:	
Name:	
Group:	
Address:	
Phone:	**Fax:**

List Men's Specialist:	
Name:	
Group:	
Address:	
Phone:	**Fax:**

Diagnosis:

1._____ **3.**_____

2._____ **4.**_____