

MALE HEALTH HISTORY QUESTIONNAIRE



Name _____ Age: _____ Today's date _____

Birth Date: _____ Weight: _____ Height: _____ Occupation: _____

1. What is the reason for this visit?

2. List medications you are currently taking:

3. Any known drug allergies? _____

4. Do you or have you used hormone replacement therapy? Yes No

If so, what? _____ When? _____ Dosage? _____

5. List natural supplements, herbs, remedies, including athletic performance supplements you are currently taking:

6. List any significant health issues (diabetes, surgeries, heart disease, etc.)

7. What was the date of your last physical exam? _____



LIFESTYLE INDICATORS

< = less than > = greater than

1. Do you use any of the following? (Circle responses)

- | | | | |
|------------------------|-------------------------------|--|---|
| Alcohol | <input type="checkbox"/> None | <input type="checkbox"/> <2 drinks / day | <input type="checkbox"/> > 2 drinks / day |
| Coffee | <input type="checkbox"/> None | <input type="checkbox"/> <2 cups / day | <input type="checkbox"/> > 2 cups / day |
| Soda | <input type="checkbox"/> None | <input type="checkbox"/> <2 cans / day | <input type="checkbox"/> > 2 cans / day |
| Sweets / refined carbs | <input type="checkbox"/> None | <input type="checkbox"/> < Twice / day | <input type="checkbox"/> > 2 Twice / day |

2. Do you smoke cigarettes / cigars or use nicotine gum? Yes No How much / often? _____

3. How would you rate your stress level? (1=Low, 10= Extreme) 1 2 3 4 5 6 7 8 9 10

4. How would you rate your stress handling? (1=Low, 10= Extreme) 1 2 3 4 5 6 7 8 9 10

5. How often do you exercise? Never rarely sometimes regularly competitively

1. Have you had a vasectomy? Yes No When? _____

2. Have you had a reverse vasectomy? Yes No When? _____

3. Have you experienced symptoms related to the vasectomy? Yes No

Explain: _____

Date of last Prostate Exam _____

Most recent PSA results _____ Date _____

SLEEP HABITS

1. How do you sleep? Well Trouble falling sleep Trouble staying asleep Insomnia

2. How many hours do you sleep a night on average? _____

3. Do night sweats wake you up? Yes No How often? _____

4. Do you wake up tired Yes No How long has this been happening? _____

5. Is your room completely dark when you sleep at night? (no night light, street lamp, TV, etc.) Yes No

6. Do you get at least 30 minutes of outside daylight time, several days each week? Yes No



SIGNS & SYMPTOMS	MILD	MODE- -RATE	SEVERE	ADDITIONAL COMMENTS
Low mood / Depression				
Irritability				
Anxiety				
Anger Aggression				
Discouragement Pessimism				
Decreased interest in activities / relationships				
Decreased initiative/ motivation / drive				
Decreased productivity at work				
Concentration problems				
Memory problems				
Foggy thinking				
Increased fatigue				
Decrease in strength stamina				
Decrease in athletic performance				
Decreased lean muscle mass				
Muscle soreness / weakness				
Body / joint aches				
Weight loss				
Weight gain				
Increased fat on hips / breasts / thighs				
Low blood sugar hypoglycemia				
Sweet cravings (carbs/chocolate)				
Caffeine/Stimulant cravings				
Salt cravings				
Constant hunger				
Elevated cholesterol				
Elevated blood pressure				
Digestive problems				
Head hair loss				
Body hair loss				
Dry skin / thinning skin				
Decreased spontaneous morning erections				
Lowered Libido				
Erectile Dysfunction (ED)				
Pain with ejaculation				
Frequent need to urinate				
Urination delayed/strained/incomplete				
Pain with urination				
Blood in the urine				
Bone loss/osteoporosis				
Other				