# Male Health History Questionnaire

(To be completed by patient)

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Weight: _____ Height: _____

**Chief Complaint(s):**

_____

_____

_____

**Prescription Drug Usage –** Please check if you use any of the following & then list exact names of any medications you are currently using:

□ Antacids, Zantac, Pepcid AC, Rolaids, etc.
□ Chemotherapy

□ Laxatives
□ Ulcer medications
□ Antibiotic/Antifungal

□ Anti-diabetic/Insulin

□ Relaxants/Sleeping pills
□ Thyroid
□ Radiation
□ Antidepressants

□ Aspirin/Acetaminophen
□ Cortisone/Anti-Inflammatory
□ Heart medications
□ High blood pressure medicine
□ Statins/Cholesterol lowering medications

□ Hormones – If so, what? _____ When? _____ Dosage? _____

Please list names of any medications you are currently taking:

_____

_____

_____

_____

_____

Are you allergic to any drugs that you know of? (if so please list names):

_____

_____

_____

**Supplement/Vitamin Usage –** Please list any supplements/vitamins you are currently taking:

_____
_____
_____
_____
_____

**Surgeries, Accidents, Trauma's –** Please list any surgeries, accidents, or trauma's you have had. Please be sure to include dates as well.

_____
_____
_____
_____
_____

**Lifestyle**

**Dietary Habits**: Describe the foods you normally eat:

BREAKFAST: _____
_____
LUNCH: _____
_____
DINNER: _____
_____
SNACKS: _____
_____

| **Do you consume the following?** | | | **If so, how much?** |
|---|---|---|---|
| 1. Soda or carbonated beverages? | YES | NO | _____ |
| 2. White flour products? | YES | NO | _____ |
| 3. Fried foods? | YES | NO | _____ |
| 4. Coffee? | YES | NO | _____ |
| 5. Fast foods regularly? | YES | NO | _____ |
| 6. Sweets and/or refined carbohydrates? | YES | NO | _____ |
| 7. Alcoholic beverages? | YES | NO | _____ |
| 8. Any tobacco products? | YES | NO | _____ |

Are you a vegetarian? YES NO

Are you currently involved in an exercise program? YES NO How often? _____

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

**Male Anatomy**

Have you had a vasectomy? YES NO When? _____

Experienced any symptoms related to the vasectomy? YES NO
If so, please explain: _____
_____

Reverse vasectomy? YES NO When? _____

Do you have any history of prostate problems? YES NO
If so, please explain: _____
_____

When was your last prostate exam? _____

What were your most recent PSA results? _____Date _____

Does your bladder always feel full? YES NO SOMETIMES

Do you experience inconsistent pressure or pain during urination? YES NO SOMETIMES

Does ejaculation cause pain? YES NO SOMETIMES

Do you experience low sex drive? YES NO SOMETIMES

Do you have premature ejaculation? YES NO SOMETIMES

**Sleep**

How well do you sleep?
□Well □ Trouble falling asleep □ Trouble staying asleep □ Insomnia

What is the average number of hours you most often sleep each night? _____

Do you wake up with night sweats? YES NO

When you wake in the morning do you still feel tired? YES NO
If yes, how often? _____

Do you keep your room completely dark at night? YES NO

**Signs & Symptoms** *(INSTRUCTIONS: Circle the number that best describes the intensity of your current symptoms. 1 = Mild (happens approximately once per month), 2 = Moderate (happens weekly), 3 = Severe (happens almost daily).* ***If you do not know the answer to a question or if it does not pertain to you simply leave it blank.***

**Section 1:**

| | | | |
|---|---|---|---|
| Do you experience bloating? | 1 | 2 | 3 |
| Fullness for extended time after meals? | 1 | 2 | 3 |
| Fatigue or low energy after eating? | 1 | 2 | 3 |
| Do you experience indigestion? | 1 | 2 | 3 |
| Uncomfortable/adverse reactions to food? | 1 | 2 | 3 |
| Weight gain? | 1 | 2 | 3 |
| Trouble losing weight? | 1 | 2 | 3 |
| Weight loss? | 1 | 2 | 3 |
| Water retention? | 1 | 2 | 3 |
| Belching/Gas? (circle) | 1 | 2 | 3 |
| Stomach burning/Nausea? (circle) | 1 | 2 | 3 |

**Section 2:**

| | | | |
|---|---|---|---|
| Do you suffer with constipation? | 1 | 2 | 3 |
| Light colored stool? | 1 | 2 | 3 |
| Loose stools? | 1 | 2 | 3 |
| Diarrhea? | 1 | 2 | 3 |
| Persistent gas? | 1 | 2 | 3 |
| Digestive problems? | 1 | 2 | 3 |

**Section 3:**

| | | | |
|---|---|---|---|
| Low blood sugar / Hypoglycemia? | 1 | 2 | 3 |
| Sweet cravings? | 1 | 2 | 3 |
| Carbohydrate cravings? | 1 | 2 | 3 |
| Caffeine/Stimulant cravings? (circle) | 1 | 2 | 3 |
| Constant hunger? | 1 | 2 | 3 |

**Signs & Symptoms, Cont'd** *(INSTRUCTIONS: Circle the number that best describes the intensity of your current symptoms. 1 = Mild (happens approximately once per month), 2 = Moderate (happens weekly), 3 = Severe (happens almost daily). If you do not know the answer to a question or if it does not pertain to you simply leave it blank.*

**Section 4:**

| | | | |
|---|---|---|---|
| Low mood/depression? (circle) | 1 | 2 | 3 |
| Mood swings? | 1 | 2 | 3 |
| Irritability? | 1 | 2 | 3 |
| Anxiety? | 1 | 2 | 3 |
| Anger/aggression? | 1 | 2 | 3 |
| Nervousness? | 1 | 2 | 3 |
| Overly reactive? | 1 | 2 | 3 |
| Short fuse? | 1 | 2 | 3 |

**Section 5:**

| | | | |
|---|---|---|---|
| Discouragement/pessimism? (circle) | 1 | 2 | 3 |
| Decreased interest in activities/relationships? (circle) | 1 | 2 | 3 |
| Decreased initiative/motivation/drive? (circle) | 1 | 2 | 3 |
| Decreased productivity at work? | 1 | 2 | 3 |

**Section 6:**

| | | | |
|---|---|---|---|
| Concentration problems? | 1 | 2 | 3 |
| Poor memory? | 1 | 2 | 3 |
| Foggy thinking? | 1 | 2 | 3 |
| Increased fatigue? | 1 | 2 | 3 |
| Lowered self-esteem/self image? (circle) | 1 | 2 | 3 |
| Care for others before yourself? | 1 | 2 | 3 |
| Sadness/crying? (circle) | 1 | 2 | 3 |

**Section 7:**

| | | | |
|---|---|---|---|
| Decrease in strength/stamina? (circle) | 1 | 2 | 3 |
| Decrease in athletic performance? | 1 | 2 | 3 |
| Decreased lean muscle mass? | 1 | 2 | 3 |
| Muscle soreness/weakness? (circle) | 1 | 2 | 3 |
| Body/joint aches? (circle) | 1 | 2 | 3 |
| Increased fat on hips/breasts/thighs? (circle) | 1 | 2 | 3 |
| Poor stamina? | 1 | 2 | 3 |
| Persistent leg cramps? | 1 | 2 | 3 |

**Signs & Symptoms, Cont'd** *(INSTRUCTIONS: Circle the number that best describes the intensity of your current symptoms. 1 = Mild (happens approximately once per month), 2 = Moderate (happens weekly), 3 = Severe (happens almost daily).* ***If you do not know the answer to a question or if it does not pertain to you simply leave it blank.***

**Section 8:**

| | | | |
|---|---|---|---|
| Elevated cholesterol? | 1 | 2 | 3 |
| Elevated blood pressure? | 1 | 2 | 3 |
| Headaches/Migraines? (circle) | 1 | 2 | 3 |
| Muscle pain/Joint aches/Backache? (circle) | 1 | 2 | 3 |

**Section 9:**

| | | | |
|---|---|---|---|
| Head hair loss/body hair loss? (circle) | 1 | 2 | 3 |
| Dry skin? | 1 | 2 | 3 |

**Section 10:**

| | | | |
|---|---|---|---|
| Lowered libido? | 1 | 2 | 3 |
| Erectile dysfunction (ED)? | 1 | 2 | 3 |
| Pain w/ ejaculation? | 1 | 2 | 3 |
| Frequent need to urinate? | 1 | 2 | 3 |
| Urination is delayed/strained/incomplete? (circle) | 1 | 2 | 3 |
| Pain with urination? | 1 | 2 | 3 |
| Blood in the urine? | 1 | 2 | 3 |
| Bone loss/osteoporosis? | 1 | 2 | 3 |