

**Male Health History Questionnaire**

(To be completed by patient)

Name: Enter Name Date: Wednesday, November 8, 2017

Date of Birth: mm/dd/yyyy Age: Enter Age

Weight: Click or tap here to enter text. Height: Click or tap here to enter text.

**Chief Complaint(s):**

Click or tap here to enter text.

**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, Rolaids, etc. [ ] Relaxants/Sleep pills

[ ] Chemotherapy [ ] Thyroid

[ ] Radiation [ ] Antidepressants

[ ] Laxatives [ ] Aspirin/Acetaminophen

[ ]  Ulcer Medications [ ]  Cortisone/Anti-Inflammation

[ ]  Antibiotic/Antifungal [ ] High Blood Pressure Medicine

[ ] Anti-Diabetic/Insulin [ ] Statins/Cholesterol Lowering Medications

[ ]  Heart Medications [ ]  Oral Contraceptives

[ ] Hormones – If so, what? Click or tap here to enter text.

When? Click or tap here to enter text. Dosage? Click or tap here to enter text.

Please list names of any medications you are currently taking:

Click or tap here to enter text.

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

Click or tap here to enter text.

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

Click or tap here to enter text.

**Surgeries, Accidents, Traumas –** Please list any surgeries, accidents, or trauma’s you have had.

Please be sure to include dates as well.

Click or tap here to enter text.

**Lifestyle**

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

BREAKFAST: Click or tap here to enter text.

LUNCH: Click or tap here to enter text.

DINNER: Click or tap here to enter text.

SNACKS: Click or tap here to enter text.

**Do you consume the following? YES NO If so, how much?**

1. Soda or carbonated beverages? [ ]  [ ]  Click or tap here to enter text.
2. White flour products? [ ]  [ ]  Click or tap here to enter text.
3. Fried foods? [ ]  [ ]  Click or tap here to enter text.
4. Coffee? [ ]  [ ]  Click or tap here to enter text.
5. Fast foods regularly? [ ]  [ ]  Click or tap here to enter text.
6. Sweets and /or refined carbohydrates? [ ]  [ ]  Click or tap here to enter text.
7. Alcoholic beverages? [ ]  [ ]  Click or tap here to enter text.
8. Any tobacco products? [ ]  [ ]  Click or tap here to enter text.

Are you a vegetarian? **Yes:**[ ]  **No:** [ ]

Are you currently involved in an exercise program? **Yes:**[ ]  **No:** [ ]  How often? Click or tap here to enter text.

How would you rate your stress level? (1=Low, 10=Extreme) Select Level

How do you rate your stress handling? (1=Poor, 10=Excellent) Select Level

**Male Anatomy**

Have you had a vasectomy? **Yes:**[ ]  **No:** [ ]  When? Click or tap here to enter text.

Experienced any symptoms related to the vasectomy? **Yes:**[ ]  **No:** [ ]

If so, please explain: Click or tap here to enter text.

Reverse vasectomy? **Yes:**[ ]  **No:** [ ]  When? Click or tap here to enter text.

Do you have any history of prostate problems? **Yes:**[ ]  **No:** [ ]

If so, please explain: Click or tap here to enter text.

When was your last prostate exam? Click or tap here to enter text.

What were your most recent PSA results? Click or tap here to enter text. Date: Enter 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? Click or tap here to enter text.

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? Click or tap here to enter text.

Do you keep your room completely dark at night? **Yes:**[ ]  **No:** [ ]

**Signs & Symptoms** *(INSTRUCTIONS: Check the number that best describes the intensity of your current symptoms. 1 = Mild (happen 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 simple 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

**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

**Signs & Symptoms Continued** *(INSTRUCTIONS: Check the number that best describes the intensity of your current symptoms. 1 = Mild (happen 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 simple leave it blank.***

**Section 5:**

Discouragement/pessimism? (circle) [ ] 1 [ ] 2 [ ] 3

Decreased interest in activities/relationships? (circle) [ ] 1 [ ] 2 [ ] 3

Decreased initiative/motivations/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

**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

**Signs & Symptoms Continued** *(INSTRUCTIONS: Check the number that best describes the intensity of your current symptoms. 1 = Mild (happen 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 simple leave it blank.***

**Section 10:**

Lowered libido? [ ] 1 [ ] 2 [ ] 3

Erectile dysfunction (ED)? [ ] 1 [ ] 2 [ ] 3

Pain with ejaculation? [ ] 1 [ ] 2 [ ] 3

Frequent need to urinate? [ ] 1 [ ] 2 [ ] 3

Bone loss/Osteoporosis? [ ] 1 [ ] 2 [ ] 3

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Patient/Guardian (Please Print)

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Patient/Guardian (Signature)

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