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PERSONAL INFORMATION

NAME _____ DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE _____ e-Mail Addr: _____ DATE OF BIRTH _____

MARITAL STATUS _____ AGE _____ NUMBER OF CHILDREN _____

OCCUPATION _____ EMPLOYER _____

ADDRESS _____ CITY/ZIP _____ TELEPHONE _____

NAME OF SPOUSE _____ SPOUSE'S OCCUPATION _____

EMPLOYER _____

ADDRESS _____ CITY/ZIP _____ TELEPHONE _____

EMERGENCY NOTIFICATION

NAME _____

ADDRESS _____ CITY/ZIP _____ TELEPHONE _____

REFERRED BY _____

MALE HEALTH HISTORY QUESTIONNAIRE

Weight: _____ Height: _____ Occupation: _____

What is the reason for this visit?

Do you have any pain at this time?

List medications you are currently taking:

Any known drug allergies? _____

Do you or have you used hormone replacement therapy? Yes No
If so, what? _____ When? _____ Dosage? _____

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

List your history of surgeries/hospitalizations (e.g., knee replacement, vasectomy)

List any health issues (e.g., diabetes)

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	None	<2 drinks/day	>2 drinks/day
Coffee	None	<2 cups/day	>2 cups/day
Soda	None	<2 cans/day	>2 cans/day
Sweets/refined carbs		<twice/day	>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=Poor, 10=Excellent) 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: _____

4. Do you have a history of prostate problems? Yes No

Explain: _____

Date of last Prostate Exam _____

Most recent PSA results _____ Date _____

SLEEP HABITS

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

How long has this been happening? _____

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	MODERATE	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 is delayed/strained/incomplete				
Pain with urination				
Blood in the urine				
Bone loss/osteoporosis				
Other				

Any other symptoms?

Please circle symptoms that apply:

Chest:	Pain	Tightness	Palpitations	Reflux	
Headaches:	Sharp	Dull	Migraines	Nausea	Vomiting
Ears:	Ringing	Drainage	Itch	Dizzy	Ache
Eyes:	Blurry	Floaters	Dry	Puffy	Twitch Circles
Sinus:	Post-Nasal-Drip	Sneezing	Sore Throat	Asthma	Cough (dry / mucus)
Allergies:	Foods	Environmental			
Fever:	Day	Late afternoon	Night	Low-grade	Are you always: Hot or Cold

For Practitioner's Use Only

Blood Pressure: _____ / _____

Pulse: _____

Tongue: _____

Diet:

Breakfast _____

Lunch _____

Dinner _____