Patient name: _____

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? _____

Patient name: _____

LIFESTYLE INDICATORS **< = less than > = greater than or stopped recently**

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

Alcohol	None	<2 drinks/day	>2 drinks/day	or stopped recently	_____(when?)
Coffee	None	<2 cups/day	>2 cups/day	or stopped recently	_____(when?)
Soda	None	<2 cans/day	>2 cans/day	or stopped recently	_____(when?)
Sweets/refined carbs		<twice/day	>twice/day	or stopped recently	_____(when?)

2. Do you smoke cigarettes/cigars or use nicotine gum or other stimulants? (circle) Y N Amount _____
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

Patient name: _____

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				
Need to shave less frequently				
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				

YOUTH HEALTH HISTORY QUESTIONNAIRE

Name _____ Today's date: _____

Age: _____ Birth Date: _____ Weight: _____ Height: _____

This questionnaire is designed to assist in providing a general overview of your child's health habits and history. Please be as detailed as possible when answering these questions!

1. What is the reason for this visit?

2. Please list any known health conditions that your child has been diagnosed with:

3. List any **medications** your child is currently taking, or has taken in the past.

4. Please indicate any history of **antibiotic** use, listing when, what, and for what purpose.

5. Are there any known drug allergies?

6. List supplements, herbs, remedies, including athletic performance supplements that your child is currently taking:

7. Do you suspect your child to use recreational drugs? If so, what:

8. List any hospital procedures/surgeries that your child has had:

LIFESTYLE INDICATORS (please fill in or circle the appropriate answer)

1. Does your child consume any of the following?

Soda	none	< 2 cans / day	> 2 cans / day	
Sweets / Carbs	none	< twice / day	> twice / day	
White Flour	none	< twice / day	> twice / day	
Milk/Dairy Products	none	< twice / day	> twice / day	
Juice	none	< twice / day	> twice / day	
Meat/Fish	none	rarely	< once a week	every day

2. How much water does your child drink each day? _____
3. Are there smokers in the child's home? Yes No
4. Does your child get consistent physical activity? Yes No
5. Please list any regular exercise or sports that your child participates in:

_____

History (please fill in or circle the appropriate answer)

1. Did your child have colic as an infant? Yes No
2. How was your child fed as an infant? Breast Bottle
   What brand / kind of formula? _____
3. Has your child had any respiratory infections? Yes No
   How often? _____
4. Does your child ever complain of back or neck pain? Yes No
   Please explain: _____
5. Does your child ever complain of arm or leg pain? Yes No
   Please explain: _____
6. Does your child ever complain of headaches? Yes No
   How often? _____
7. Has your child had ear infections? Yes No
   Age of the first occurrence and frequency: _____
8. Do they typically occur in the same ear? Yes No Which ear? Right Left Both
9. Please list any illnesses that your child has had and approximate dates of occurrence:

_____

_____

10. Has your child been vaccinated? Yes No Recently? Yes No
11. Please describe any reactions that your child has had to past or recent vaccinations:

_____

12. Please list any other concerns you have regarding your child's health:

_____

_____

Sleep Habits (please fill in or circle the appropriate answer)

1. How well does your child sleep?

   Well Trouble falling asleep Trouble staying asleep Insomnia

2. Does your child wake up tired? Yes No

3. How many hours does your child sleep on an average night? _____

4. Does your child take naps? Yes No

5. Does your child have nightmares? No Sometimes Often

For Cycling Females Only (please fill in or circle the appropriate answer)

1. Age of onset of menarche (first period): _____

   Approximate Date: _____

2. Is your child currently using any method of birth control? Yes No

   What kind? Oral Pill Injected Patch Ring

3. How long has your child been using birth control? _____

4. Please describe any symptoms that your child may have experienced while using birth control (i.e. yeast infections, heavy / light bleeding, moodiness, weight gain, acne, sweet cravings, palpitations, fatigue):

_____

_____

_____

_____

5. First day of last period: _____

6. Length of typical period: _____

7. Is menstrual cycle regular? Yes No Not Always

   Details: _____

8. How many pads and / or tampons (please circle) are used on heavy days?

_____

9. Any knowledge of passing clots? Yes No

   How often? _____

10. Any spotting between periods? Yes No

    At what point in cycle? _____

11. Does your child experience cramping? None Mild Moderate Severe

    At what point in the cycle? _____

INSTRUCTIONS: Please mark the following symptoms as they apply.
Please be as detailed as possible.

SIGNS & SYMPTOMS	MILD	MODERATE	SEVERE	MORE INFORMATION
Low Mood				
Lowered Self-Esteem				
Discouragement				
Sadness / Crying				
Reserved / Withdrawn				
Decreased Interest in Activities				
Decreased Initiative / Motivation				
Behavior Problems				
Aggression				
Anger				
Anxiety				
Fear				
Difficulty Concentrating				
Foggy Thinking				
Memory Problems				
Constant Hunger				
Never Hungry / Anorexia				
Weight Loss				
Weight gain				
Decrease in Strength / Stamina				
Decrease in Athletic Performance				
Fatigue				
Anemia				
Headaches / Migraines				
Body / Joint / Backaches				
Digestive Problems				
Irritable Bowel				
Constipation				
Loose Stool / Diarrhea				
Bloating				
Frequent Urination				
Bedwetting				
Allergies				
Asthma				
Throat Clearing				
Excessive Mucous / Runny Nose				
Dry Skin				
Acne				
Cold Sores				
Infections / Lowered Immunity				