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MALE MEDICAL QUESTIONNAIRE

NAME: DATE OF BIRTH:

CHIEF COMPLAINT

- What is your primary problem?

  ____

  ____

- What kind of physicians have you seen for your health problem(s)?

  ____

  ____

PAST MEDICAL HISTORY

ILLNESS		YEAR	ILLNESS		YEAR
Y / N	Cancer	______	Y / N	Irrit. Bowel Syndrome	______
Y / N	Chronic Fatigue Syndrome	______	Y / N	Kidney Disease	______
Y / N	Colitis	______	Y / N	Lupus	______
Y / N	Diabetes	______	Y / N	Mitral Valve Prolapse	______
Y / N	Elevated Cholesterol	______	Y / N	Mononucleosis	______
Y / N	Elevated Triglycerides	______	Y / N	Multiple Sclerosis	______
Y / N	Fibromyalgia	______	Y / N	Oral Yeast/Mouth Inf.	______
Y / N	Gall Bladder Disease	______	Y / N	Pelvic Inf. Disease	______
Y / N	Heart Disease	______	Y / N	Pneumonia	______
Y / N	Heart Attack	______	Y / N	Seizures	______
Y / N	HIV Positive	______	Y / N	Sex. Trans. Disease	______
Y / N	Hypertension	______	Y / N	Sleep Apnea	______
Y / N	Hyperthyroidism	______	Y / N	Stroke	______
Y / N	Hypothyroidism	______	Y / N	Tuberculosis	______
Y / N	Hepatitis	______	Y / N	Ulcerative Colitis	______

Lifetime Antibiotic Use

Approximately how many times have you used antibiotics over the past year? _____x
Over the past 5 yrs? _____x/yr 10 yrs? _____x/yr 20 yrs? _____

For what illness(es)? ________________________________ What year? _______
How long did you take the antibiotics continuously? ____________________________

Was there any time in the past when you used antibiotics for 30 days or longer continuously for acne or illness? Y / N

If for acne, did you take Accutane? Y / N For how long? ______________________

Review of Symptoms

Headaches

Y / N Do you have headaches? ______x/week ______x/month For how long? _______
What do you take to relieve your headaches? ____________________________

Nose

Y / N Do you have colds, runny/stuffy nose, or sinus problems?
How often? _____x/week _____x/month
Y / N Do you snore? For how long? _____months _____years

Asthma

Y / N Did you ever have asthma or wheezing? How often? _____x/month_____x/year

Heart

Y / N Have you ever had a heart attack? When ________________________________
Y / N Do you ever feel your heart skip a beat? How often? ______________________
For how many years? _____
Y / N Do you have chest pain? How often? ____________________________________
How long does the pain last? ____________________ How many years? _______
The pain is: sharp / stabbing / dull / aching
It radiates to your: neck / back / shoulders
Y / N Do you feel like you are going to pass out?

Gastrointestinal System

Y / N Do you have: abdominal cramping / bloating / excessive belching / intestinal gas? How often? _____x/week For how long? ________________

Urinary Tract/Prostate

Y / N Have you ever had bladder infections/kidney infections?
How many x/year? _____ For how many years? _____
Y / N Have you ever had kidney stones? How many times? _____
Year of last episode _____
Y / N Do you have burning upon urination?
Y / N Do you have increased frequency of urination?
Y / N Have you ever had a prostate infection? How many times? ____________
How many times per year? ________ For how many years? ___________
Between what years? ______-______
Y / N Do you have difficulty stopping or starting your stream of urine?
For how many years? _________
Y / N Do you have difficulty completely emptying your bladder or decreased urinary flow? For how many years? __________
Y / N Have you had a prostate exam? Date of the last exam_____/_____mo/yr

Skin

Y / N Do you have any unexplained skin rashes or itchy skin?
For how long? _____months _____years
Do you know the cause of your rashes/itchy skin? _______________________
Y / N Do you have dry skin? For how many years? _____

Thyroid

Y / N Have you been diagnosed with a thyroid disorder? Year diagnosed ________
Y / N Were you diagnosed with hyperthyroidism (high)?
Y / N Were you diagnosed with hypothyroidism (low)?
Y / N Did you ever take thyroid medication? What year did you quit? _____
Name of medicine ____

Malaise/Fatigue

Y / N Do you feel you should have more energy?
What is your average energy level on a scale of 1-10 with 10 meaning brimming with energy and 1 meaning the inability to get out of bed?
ENERGY LEVEL: _____/10 For how many years? _________

Fluid Retention

Y / N Do you have swelling beneath your eyes or dark circles under your eyes?
_____x/month For how many years? _____
Y / N Do you have swelling of your face, hands, or feet? _____x/month
For how many years? _____

Cold Sensitivity

Y / N Do you have cold hands or feet? For how many years? ______
Y / N Are you sensitive to the cold or get chilled easily? For how many years? ______

Sweating

Y / N Do the palms of your hands or feet perspire unusually?
For how many years? ______
Y / N Do you have decreased perspiration? For how many years? ______

Hair Condition

Y / N Do you have coarse or fine hair? For how many years? ______
Y / N Have you ever had significant hair loss? For how long? ______months ______years

Weight

Y / N Have you had significant weight gain? How many pounds? _______ pounds
Since what year? ______
Y / N Do you have difficulty losing weight? For how long? ______

Cognitive Ability

Y / N Do you ever feel that you have decreased mental sharpness?
Y / N Do you have a poor short-term memory?
For how many years have you had these problems? ______

Mood

Y / N Do you ever feel discouraged, blue or depressed more than 10% of the time?
What percent of the time? _______% For how many years? ______
Y / N Have you ever taken anti-depressants?
Which one(s)? ____
Between what ages? _______ y.o. and _______ y.o.

Bowel Function

Y / N Do you have a bowel movement every day?
How many times per week do you have a bowel movement? _______x/week
Y / N Do you alternate between constipation and diarrhea? How many years? ______

Joint Function

Y / N Do you have pain in any joint(s)? Circle which of the following joints:

Neck	Lower Back	Elbows	Wrists	Finger joints
Shoulder	Hips	Knees	Ankles	Toe Joints

How many times per week? _____ For how many years? _____

Muscle

Y / N Do you have muscle weakness? For how many years? _____
Y / N Do you ever have generalized muscle aches/cramping? Which muscles?
____
For how many years? _____
Y / N Do you have any numbness or tingling in the extremities?
Which ones? __________________________________ For how many years? _____

Sleep

Y / N Do you have insomnia or restless sleep? For how many years? _____
Y / N Do you feel tired after a full night's sleep? For how many years? _____
Y / N Do you have afternoon fatigue?
How many hours of sleep do you require? __________hours/night?

Libido

Y / N Have you had a decrease in sexual desire? For how long? __________________

Night Sweats

Y / N Do you have night sweats? How often? _______ For how many years? ________

General Well Being

Have you noticed any of the following, or a decline in any of the following:

Y / N	Initiative	______ years	Y / N	Decisiveness	______ years
Y / N	Assertiveness	______ years	Y / N	Abstract Thinking	______ years
Y / N	Confidence	______ years	Y / N	Analytical Ability	______ years
Y / N	Goal Orientation	______ years	Y / N	Muscle Mass	______ years
Y / N	Mood Swings	______ years	Y / N	Muscle Strength	______ years