

MALE HEALTH HISTORY QUESTIONNAIRE

Name _____ Age: _____ Today's date: _____

Address: _____

State: _____ Zip _____ Phone: Home _____ Cell: _____

Email _____

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?

Male History Questionnaire - B -

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

Male History Questionnaire - C -

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

CURRENT HEALTH CONDITION

PURPOSE OF THIS APPOINTMENT _____

HOW DID IT HAPPEN? _____

WHAT GENETIC WEAKNESSES RUN IN YOUR FAMILY?

TODAYS CONDITION STARTED WHEN? _____

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION? _____

WHAT ACTIVITIES LESSEN YOUR CONDITION? _____

IS CONDITION WORSE DURING CERTAIN TIMES OF THE DAY? _____

IS THIS CONDITION INTERFERING WITH WORK? _____ SLEEP? _____ ROUTINE? _____

IS CONDITION GETTING PROGRESSIVELY WORSE? _____

OTHER DOCTORS SEEN FOR THIS CONDITION _____

TYPE OF TREATMENT _____ RESULTS _____

Habits

How many bowel movements a day? _____ Full and complete? _____ No _____

How is your energy through out the day? _____ High _____ Average _____ Low

Experience: Indigestion after meals _____? Sleepiness _____? Bloating _____? Undigested food in stool? _____

Are you at Your _____ ideal weight _____ underweight _____ overweight?

If over weight, How much _____?

- Alcohol:
 - Type _____
 - Amount _____
 - Diet: Salt intake _____
 - Fat intake _____
 - Other _____
- Continuity disturbances _____
- Early morning awakenings _____
- Daytime drowsiness _____
- Other _____
- Smoking: Packs daily _____
- How long _____
- Interested in stopping? _____
- Exercise routine: _____
- Caffeine: Coffee, cups daily _____
- Other _____
- Sleep: Difficulty falling asleep _____

Do You have history of eating disorders? _____

How many hours sleep do you get each night? _____ Do you feel rested when you wake up? _____

How many times do you exercise each week? _____ For how Long? _____ What type? _____

Have you traveled outside U.S. within the past three years? _____

Give example of an average day of eating including drinks & snacks:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Dessert _____

Drinks _____

Do you have any other health related issues, concerns or comments not yet covered? _____

How did you hear about **Alternative Strategies**? _____

Where do you purchase health related products (vitamins, herbs, teas, etc)? _____

FINANCIAL AGREEMENT

I understand that all services are rendered on a cash, check, or credit card basis. Unless other arrangements have been made and approved, I agree to pay for each session at the time of the session. I also agree to the \$20 returned check charge in the event that my check is returned.

Date _____ Client's Signature _____