# 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? _____

**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 When/How 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 | | | | |
| 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 | | | | |