

MALE HEALTH HISTORY QUESTIONNAIRE

Name _____ Age: _____ Today's date: _____

Birth Date: _____ Weight: _____ Height: _____ Occupation: _____

What is the reason for this visit?

List medications you are currently taking:

Any known drug allergies? _____

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

List any significant health issues (diabetes, surgeries, heart disease, etc.)

Are you currently under another physician's care? _____

What was the date of your last physical exam? _____

LIFESTYLE INDICATORS

Do you use any of the following (circle one response)?

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

Do you smoke cigarettes/cigars or use nicotine gum? Yes No How much/often? _____

What do you consider your general stress level to be? Low Moderate High Severe

How often do you exercise? never rarely sometimes regularly competitively

Do you or have you ever taken athletic/energy/performance supplements? Yes No

If so, what? _____

Do you or have you used hormone replacement therapy? Yes No

If so, what? _____ When? _____ Dosage? _____

Have you had a vasectomy? Yes No When? _____

Have you had a reverse vasectomy? Yes No When? _____

Have you experienced symptoms related to the vasectomy? Yes No

Explain: _____

Do you have a history of prostate problems? Yes No

Explain: _____

SLEEP HABITS

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

How long has this been happening? _____

How many hours do you sleep a night on average? _____

Do night sweats wake you up? Yes No How often? _____

Do you wake up tired? Yes No How long has this been happening? _____

Is your room completely dark when you sleep at night? (no night light, street lamp, TV, etc.) Yes No

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)				
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				