

# MALE HEALTH HISTORY QUESTIONNAIRE

Name \_\_\_\_\_ Age: \_\_\_\_\_ Today's date: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Occupation: \_\_\_\_\_

1. What is the reason for this visit?

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2. List medications you are currently taking:

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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:

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

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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    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

<b>SIGNS &amp; SYMPTOMS</b>	<b>MILD</b>	<b>MODERATE</b>	<b>SEVERE</b>	<b>ADDITIONAL COMMENTS</b>
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				