Patient name: _____

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? _____

Patient name: _____

LIFESTYLE INDICATORS **< = less than > = greater than or stopped recently**

1. Do you use any of the following? (circle responses)

Alcohol	None	<2 drinks/day	>2 drinks/day	or stopped recently	_____(when?)
Coffee	None	<2 cups/day	>2 cups/day	or stopped recently	_____(when?)
Soda	None	<2 cans/day	>2 cans/day	or stopped recently	_____(when?)
Sweets/refined carbs		<twice/day	>twice/day	or stopped recently	_____(when?)

2. Do you smoke cigarettes/cigars or use nicotine gum or other stimulants? (circle) Y N Amount _____
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

Patient name: _____

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				