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Male Extensive Medical and Health Survey

PLEASE DO NOT WEAR PERFUMES, AFTERSHAVES OR SCENTS. SOME PATIENTS HAVE ALLERGIES.
MAIL COMPLETED FORM TO OFFICE AND KEEP A COPY . WE WILL CONTACT YOU TO SCHEDULE YOUR APPOINTMENT.
THIS IS AN IMPORTANT PART OF YOUR VISIT. ACCURATE COMPLETION OF THIS FORM WILL ASSURE THAT YOU RECEIVE THE BEST POSSIBLE CARE IN THE TIME SET ASIDE FOR YOUR VISIT.
PLEASE BRING RECENT MEDICAL RECORDS, IF POSSIBLE, ESPECIALLY LAB TEST OR HOSPITAL DISCHARGES.

Name: Age: Sex: Marital status: M S D W Birth date:

Address: City: St: Zip:

Phones: Home Work: Fax: Cell:

Occupation: Past occupations:

Name of spouse/partner: Age: Occupation:

Best days & times to reach you: E-mail:

How did you hear about us? Travel time to office:

Credit Card info, if indicated: Card holder name: Credit Card type: MC VISA DIS

Credit Card #: Exp. date: V-Code (3 digits on back of card):

Credit Card billing address:

PLEASE DESCRIBE YOUR MAJOR PROBLEMS AND/OR SYMPTOMS. If none, please write your reason for seeking this consultation. Please be clear and concise to help us help you. Include when the symptoms first appeared. Write what you can in the space provided. If you need more space add a separate sheet of paper.

If you have seen other physicians for these problems, indicate the results of these evaluations:

List your short-term goals for coming to this office:

List your long-term goals:

Height:	Weight:	Lowest adult wt:	Highest adult wt:	Desired wt:
Last Dr. visit:	Blood pressure:	Heart rate:	Allergies/sensitivities list:	

Smoke	Y N	Year started:	Packs per day:	Year stopped:
Alcohol	Y N	Year started:	How much:	Year stopped:
Street drugs	Y N	Type:	How often:	Year stopped:
Caffeine	Y N	Type:	How much:	How much:
Sleep problems	Y N	Type:	Type:	Type:
Exercise	Y N	Type:	How Often:	How often:
Cosmetics Y N	Perfumes Y N	Aftershaves Y N	Scented soaps Y N	

Do you have now or have you ever had any problems with any of the following?

1	HEAD, NECK	Y N	13	PENIS, TESTICLES	Y N
2	EYES, VISION	Y N	14	BACK, SHOULDER BLADES	Y N
3	EARS, HEARING	Y N	15	RIBS, HIPS	Y N
4	TEETH	Y N	16	ARMS, LEGS	Y N
5	NOSE, MOUTH, VOICE	Y N	17	NERVE, BRAIN DISEASE	Y N
6	LUNGS, BREAST, CHEST	Y N	18	SEIZURE, MIGRAINES	Y N
7	HEART	Y N	19	SKIN PROBLEMS	Y N
8	ARTERIES, VEINS	Y N	20	BLOOD DISEASES, SPLEEN	Y N
9	STOMACH, GALLBLADDER	Y N	21	GLANDS, OBESITY	Y N
10	LIVER, PANCREAS	Y N	22	CANCER	Y N
11	BOWELS, RECTUM, HERNIA	Y N	23	PSYCHIATRIC PROBLEMS	Y N
12	KIDNEY, BLADDER	Y N	24	OTHER CONDITIONS	Y N

Explain Any "Yes" Answers:

Major Hospitalizations-List:

Heart Disease Risk Factors

Y N	Age Years - Male ≥ 45 Female ≥ 55 or early menopause without estrogen replacement therapy
Y N	Family history of premature Heart Disease (definite myocardial infarction or sudden death before 55 in father / close male relative, or 65 in mother / close female relative)
Y N	Current cigarette smoker
Y N	Hypertension (Blood pressure ≥ 140/90 mm Hg confirmed by measurements on several occasions or taking antihypertensive medication
Y N	Low HDL (good) cholesterol (<35 mg/dl confirmed by measurements on several occasions [0.9 mmo/L]
Y N	Diabetes mellitus (sugar)
Y N	High HDL (good) cholesterol (≥ 60 mg/dl [1.6 mmo/L]

Your Tests, Specify if known:		Last Physical:	Xrays:	GI Series:
Gall bladder:	Kidney:	EKG:	Stress EKG:	Angiogram:
Ultrasound:	Blood Tests:	Others:		

Name: _____

Name: _____

Have you ever been on prolonged antibiotic therapy: Y N If Yes, what & why:

Have you traveled out of the country? Y N If yes, where & when?

Have you been treated for parasites? Y N Have you been tested for parasites? Y N

Do you do any stress reduction/relaxation such as meditation, yoga, self-hypnosis, etc.? Y N

What:	How Often:	Length of Sessions:	
Your stress level: Low Moderate High			
Sleeping Habits:	Hours/Night:	Restless or Restful	What Time You Retire:
	Wake During Night: Y N	Dream: Y N	

What are your hobbies or interests?

Immunizations, if Known:

Smallpox:	Polio:	Mumps:	Pneumonia:	Pertussis:
Tetanus:	Flu:	Measles:	Diphtheria:	Other:

Did your mother have any problems during her pregnancy with you (illness, stress, smoking, meds, alcohol)? Y N

Were you bottle or breast fed? Was your home life (circle): loving supportive stressful abusive peaceful

loud argumentative educational alcoholic friendly single-parent lonely or other—list

Childhood Illnesses (circle): colic eczema asthma polio allergies bronchitis pneumonia meningitis rheumatic fever recurrent colds

ear infections thrush German measles bedwetting tonsils out persistent diaper rash learning problems hyperactive or others—list

Family History	Living	Age	Health Problems**, Mental Illnesses or Cause of Death
Father	Y N		
Mother	Y N		
Brothers/Sisters	#		
Children	#		

** Cancer, Thyroid, Hypertension, Heart Disease, Stroke, Diabetes, Aortic Aneurysm, Asthma

Other household members now living with you. Include family members, non-family members and pets.

Name	Relationship	Age	Occupation

Please indicate if you or any family members or grandparents, ever had any of the following problems—Specify

Alcoholism	Allergies
Arthritis	Asthma
Cancer	Epilepsy
Colitis/Crohn's Ds.	Diabetes
Herpes	Shingles
Drug Problems	Eczema
Heart Disease	High Blood Pressure

Please indicate if you or any family members or grandparents, ever had any of the following problems—Specify

Hepatitis	Frequent Infections
High Cholesterol	Bleeding/Bruising
Anemia	Low Blood Sugar
Digestive Disease	Weight Problems
Psoriasis	Urinary infections
Lupus	Mental Illness
Migranes	Pneumonia
Polio	Prostate Problems
Rheumatic Fever	Rheumatoid Disease
Sinus Disease	Strokes
Thyroid Problems	Tuberculosis
Ulcers	Venereal Disease

Comments/Explanations

Read carefully through the list of symptoms in each group, and put a check mark next to each symptom that you have. (If you check off the same symptom in more than one group, that's fine.)

Symptom Group 1		**Symptom Group 2**		**Symptom Group 6**	
Weight loss		Hair loss		Debilitating fatigue	
Loss of muscle		Prostate enlargement		Low blood pressure	
Lower sex drive		Irritability		Intolerance to exercise	
Fatigue		Puffiness/bloating		Unstable blood sugar	
Enlarged breast		Headaches		Thin and/or dry skin	
Lower stamina		Breast enlargement		Foggy thinking	
Softer erections		Weight gain		Brown spots on face	
Gallbladder problems					
TOTAL BOXES CHECKED		***TOTAL BOXES CHECKED***		***TOTAL BOXES CHECKED***	

Date of last prostate exam: Was it normal? Y N If no, explain:

Date of last PSA? What was the value?

Date last stools checked for blood: Was it normal? Y N If no, explain:

Date of last sigmoidoscopy or colonoscopy? Was it normal? Y N If no, explain:

Living Environment—circle: Urban Suburban Country Seaside Lakeside

Type of Heat: Humidifier: Y N Wood Stove: Y N Type of Insulation:

Is the Cellar: Dry Damp Musty Dusty Is the House: Old New Has it been treated for pests? Y N What Kind?

Do you use feather or down covers, comforters or jackets? Y N Do you have an air filter or cleaner? Y N

Are there animals at home or places you visit frequently? Y N What kind:

Do you use strong chemical cleaners, solvents, paints, etc.? Y N What?

Notes:

Name: _____

Name: _____

Fill in "C" for current problem; "I" for an intermittent problem; "P" for a past problem

___ Headaches	___ High blood pressure	___ Weakness
___ Neck lumps or swelling	___ Skipped heartbeats	___ Painful feet
___ Loss of balance	___ Racing heart	___ Leg cramps
___ Dizzy spells	___ Chest pain or pressure	___ Trembling or tremors
___ Vertigo	___ Swollen feet or ankles	___ Seizures or epilepsy
___ Blackouts or fainting	___ Difficulty breathing at night	___ Numbness or tingling
___ Blurry vision	___ Varicose veins or phlebitis	___ Skin tumors
___ Double vision	___ Recurring indigestion	___ Dry skin
___ Cataracts	___ Nausea or vomiting	___ Acne
___ Eye pain or itching	___ Intestinal gas/ flatulence	___ Eczema
___ Watering eyes or redness	___ Belching	___ Skin rashes
___ Hearing difficulties	___ Bloating	___ Psoriasis
___ Earaches or drainage	___ Abdominal pain or cramps	___ Dandruff or seborrhea
___ Noises or ringing in ears	___ Constipation	___ Hives
___ Recurrent ear infections	___ Diarrhea or loose stools	___ Itching or burning skin
___ Dental problems/ decay	___ Rectal itching	___ Easy bruising
___ Sore or bleeding gums	___ Blood with stools	___ Hypothyroid (low)
___ Sore tongue	___ Black stools	___ Hyperthyroid (high)
___ Coated tongue	___ Pain in rectum	___ Weight gain
___ Loss of taste or smell	___ Jaundice	___ Weight loss
___ Sores in or around mouth	___ Hepatitis/pancreatitis	___ Feel excessively warm
___ Difficulty swallowing	___ Colitis	___ Feel excessively cold
___ Cold sores or blisters	___ Crohn's disease	___ Loss of appetite
___ Sinus or nasal congestion	___ Diverticulitis/diverticulosis	___ Constant hunger
___ Runny nose	___ Frequent urination	___ Fatigue or weariness
___ Frequent colds	___ Brown or red urine	___ Night sweats
___ Nasal polyps	___ Decreased force of urine	___ Diabetes
___ Sore throats	___ Continual urge to urinate	___ Low blood pressure
___ Swollen glands	___ Difficulty starting urination	___ Nervousness or anxiety
___ Recurrent fevers or chills	___ Kidney or bladder infection	___ Depression
___ Hoarse voice	___ Involuntary escape of urine	___ Suicidal thoughts
___ Shortness of breath	___ Venereal disease	___ Sought psychological help
___ Wheezing or gasping	___ Aching muscles or joints	___ -MEN ONLY-
___ Coughing	___ arthritis	___ Painful testicles
___ Coughing blood	___ Joint stiffness	___ Hernia
___ Chest colds or pneumonia	___ Back or neck pain	___ Prostate problems
___ Heart murmur	___ Osteoporosis	___ Sexual dysfunction

Fill in the number that best describes your feelings most recently.

0 = not at all; 1 = a little bit; 2 = moderately; 3 = quite a bit; 4 = extremely

___ Nervousness or shakiness inside

___ Repeated unpleasant thoughts

___ Loss of sexual interest or pressure

___ Feeling exuberant or enthusiastic

___ The idea that others can control your thoughts

___ Feeling others are to blame for your troubles

___ Trouble remembering things

___ Feeling afraid in open spaces or outside

___ Feeling critical of others

___ Feeling that your goals and aims are clear in life

___ Thoughts of ending your life

___ Hearing voices that others do not hear

___ Feeling easily annoyed or irritated

___ Crying easily

___ Feeling happy and lighthearted

___ Feeling shy or uneasy with the opposite sex

___ Feeling of being trapped or caught

___ Temper outbursts that you cannot control

___ Blaming yourself for things

___ Feeling blocked in getting things done

___ Feeling in control of your life

___ Feeling lonely

___ Feeling blue or depressed

___ Facing daily tasks is a source of pleasure

___ Worrying too much about things

___ Feeling no interest in things

___ Feeling fearful or afraid

___ Your feelings are hurt easily

___ Others are aware of your private thoughts

___ Others do not understand you

___ Must do things very slowly to insure correctness

___ Feeling watched or talked about by others

___ Difficulty making decisions

___ Your mind is in a fog

___ Having a lump in your throat

___ Feeling tense or keyed up

___ Heavy feeling in your arms or legs

___ Thoughts of death or dying

___ Feeling uneasy when people are watching you

___ Having to repeat the same actions over and over

___ Having urges to break or smash things

___ Feeling self-conscious with others

___ Having a good sense of humor

___ Feeling everything is an effort

___ Spells of panic or terror

___ Getting into frequent arguments

___ Feeling relaxed

___ Felling nervous when you are left alone

___ Feeling that others do not give you proper credit for your achievements

___ Feeling your life is filled with good things

___ Feeling lonely even when you are with people

___ Never feeling close to another person

___ Feeling at peace with your surroundings

___ Feelings of guilt

___ Having the idea that something is wrong with your mind

___ Feeling very responsible for others

___ Feeling able to turn to your family for help when something is troubling you

___ Feeling satisfied with your family's affection and responses to your emotional needs

___ Feeling harmony in your personal world

___ Feeling angry

___ Feeling that your ability to find meaning in life is very great

___ Being a responsible person

___ Feeling good about your personal relationships

___ Feeling afraid to travel by bus, train, or in cars

___ Feeling your personal existence is valuable

Name: _____

Name: _____

This index indicates degrees of stress related to changes in life. In studies, many people who scored over 300 became ill within a 3 to 6 month period. If an event has been true for you in the past year, or is about to happen, circle the associated point value. If an unlisted event has occurred, add it to the bottom of the list and assign it a point value. Add up the points.

Death of spouse or partner	100
Divorce	73
Separation from spouse or partner	65
Jail term	63
Death of a close family member	63
Personal injury or illness	53
Marriage/commitment to a partner	50
Fired at work	47
Reconciliation with a spouse/partner	45
Retirement	45
Change in health of family member	44
Pregnancy	40
Sex difficulties	39
Addition of new family member	39
Business readjustment	39
Change in financial state	38
Death of a close friend	37
Change to a different line of work	36
More arguments with spouse/partner	35
Mortgage over 50,000	31
Foreclosure of mortgage or loan	30
Change in work responsibilities	29
Child leaving home	29
Trouble with in-laws	29
Outstanding personal achievements	28
Spouse/partner begins/stops work	26
Begin or end school	26
Change in living conditions	25
Revision of personal habits	24
Trouble with boss or employee	23
Change in work hours or conditions	20
Change in residence	20
Change in schools	20
Change in recreation	19
Change in church activities	19
Change in social activities	18
Mortgage or loan under 50,000	17
Change in sleeping habits	16
Change in eating habits	15
Vacation	13
Christmas approaching	12
Minor violations of the law	11
Other	
Other	
TOTAL OF ALL POINTS	

Specify what foods and beverages you normally consume during a typical day.

Weekdays

Breakfast

Snack

Lunch

Snack

Dinner

Snack

Weekends

Breakfast

Snack

Lunch

Snack

Dinner

Snack

Do you binge? Y N Use foods for reward or escape? Y N

If so, what foods or beverages do you use, and how often?

What foods would be most difficult to give up?

Do you have specific food cravings? Y N What Foods?

What work or scheduling considerations might create difficulties for you trying to change your eating or any other health habits?

List any known food allergies:

Please check the following boxes according to the frequency of your personal habits.

Frequent **= at least once per day;** ***Often*** **= several times per week;** ***Occasional*** **= once per week or less;**
Seldom **= once or twice per month or less;** ***Never*** **= almost total avoidance**

Frequent	Often	Occasional	Seldom	Never	
					1. Alcoholic beverages
					2. Eat at restaurants
					3. Eat at fast food restaurants
					4. Pastries, cookies, candies, ice cream, other sweets
					5. Add sugar to coffee, tea, cereals or other foods
					6. Colas or other soft drinks
					7. Instant breakfasts, pop tarts, doughnuts, muffins
					8. Cold breakfast cereals
					9. Caffeine drinks (coffee, tea, cola, chocolate)
					10. Deep fried foods
					11. Margarine of any type
					12. Whole grain hot cereals (oatmeal, wheatena, etc.)
					13. Meat (beef or veal, pork or ham, liver ,lamb)
					14. Chicken or turkey -circle : regular or free range
					15. Fresh fish
					16. Processed meat (bologna, turkey roll, sausage, etc.)
					17. Fresh raw fruit
					18. Fresh vegetables, raw or cooked
					19. Salads
					20. Whole grains or whole grain breads
					21. White bread or white flour products
					22. Beans and legumes (lentil, kidney, chickpea, etc.)
					23. Yogurt– circle: whole or low-fat, plain or flavored
					24. Milk– circle: whole or low- fat or skimmed
					25. Cheese
					26. Eggs– circle: regular or free range
					27. Salt
					28. Herbs, fresh and dried, or spices
					29. Drink adequate water—circle: tap, filtered, or bottled
					30. Eat excessively if bored or depressed
					31. Swallow food before chewing well
					32. Hurried or rushed meals
					33. Stuff yourself
					34. Read and understand food labels
					35. Sneak or hide foods
					36. Adequate fiber or roughage in the diet
					37. Artificial sweeteners (saccharin, Nutrasweet, etc.)
					38. Shop at health food stores

Name: _____

DO NOT PASTE OR ATTACH LABELS

INGREDIENT	AMOUNT IN MULTIPLE VITAMIN-MINERAL	AMOUNT IN INDIVIDUAL SUPPLEMENTS	DAILY TOTAL
Vitamin A			
Beta-Carotene			
Vitamin B1 (Thiamine)			
Vitamin B2 (Riboflavin)			
Vitamin B3 (Niacin)			
Vitamin B3 (Niacinamide)			
Vitamin B5 (Pantothenic Acid)			
Vitamin B6 (Pyridoxine)			
Vitamin B12 (Cobalmin)			
Vitamin C			
Vitamin D			
Vitamin E			
Vitamin K			
Biotin			
Folic Acid			
Choline			
Inositol			
Bioflavonoids			
Boron			
Calcium			
Chromium			
Copper			
Iodine			
Iron			
Magnesium			
Manganese			
Molybdenum			
Phosphorus			
Potassium			
Selenium			
Silica			
Zinc			

Name: _____

INGREDIENTS (Herbals, etc)	AMOUNT IN SINGLES	AMOUNT IN BLENDS	DAILY TOTAL

MEDICATIONS	DOSE	DIRECTIONS	FOR WHAT?

If you need more space add a separate sheet of paper.

Name: _____