IRIE Natural Center for Health

MALE GENERAL HEALTH HISTORY QUESTIONNAIRE

PATIENT INFORMATION:			
Name		Date	
Height	Weight	DOB	Age

WHAT IS YOUR MAJOR SYMPTOM/PROBLEM?	DATE SYMPTOM BEGAN
1.	
2.	
3.	

PAST HEALTH HISTORY:	CIRCLE ALL THAT APPLY
Cardiovascular disease:	chest pain/hear failure/ murmur/ vascular disease/ blood clots/ fainting/ lower extremity edema
Respiratory disease:	shortness of breath/asthma/ bronchitis/ pneumonia/ allergies/ hay fever
Gastrointestinal disease:	heart burn/gall bladder/ gall stones /diarrhea/constipation
Genitourinary disease:	overactive bladder/ frequent urination / pain urination / difficult urination/ prostate enlargement/ BPH
Other:	Diabetes/ High Blood Pressure/ Cancer/ Depression/ High Cholesterol/ Sleep Apnea

MEDICATIONS: (All medication including aspirin or vitamin supplements)	DOSAGE	HOW OFTEN TAKEN

ALLERGIES TO MEDICATION	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

When was you last blood work? _____
Any seizure history? □ Y □N
Are you currently taking anticoagulants such as Aspirin, Warfarin or Coumadin? □ Y □N
Exercise: □Sedentary (No exercise) □Mild exercise □Occasional exercise □Regular vigorous exercise
Do you make/eat home cooked meals? □ Y □N Do you eat fast food meals? □ Y □N _____ times/ weekly
Do you smoke cigarettes? □ Y □N #per day _____ Former Smoker? □
Do you drink alcohol? □ Y □N □ occasionally
Any history of illegal steroid use, Past or Present? □ Y □N
Are you currently working? □ Y □N Occupation? _____
Do you feel anxious? □ Y □N Depressed? □ Y □N Panic Attacks? □ Y □N

PLEASE COMPLETE THE BACK OF THIS FORM

SYMPTOMS OF LOW TESTOSTERONE LEVELS		
Difficulty concentrating	□ Y	□N
Moodiness	□ Y	□N
Depression	□ Y	□N
Weight Gain	□ Y	□N
Decreasing sex drive	□ Y	□N
Increasing Fatigue	□ Y	□N
Decreased energy	□ Y	□N
Daytime Sleepiness	□ Y	□N
Poor Sleep Habits	□ Y	□N
Erectile Dysfunction	□ Y	□N

Do you feel pain or burning with urination?	□ Y	□N
Any blood in you urine?	□ Y	□N
Do you feel beaning discharge from penis?	□ Y	□N
Has the force of your urination decreased?	□ Y	□N
Have you had any kidney, bladder, or prostate infection within the last 12 months?	□ Y	□N
Do you have any problems emptying your bladder completely?	□ Y	□N
Any difficulty achieving or sustaining erection or ejaculation?	□ Y	□N
Any problems reaching climax?	□ Y	□N
Date of last prostate and rectal exam?	□ Y	□N
Any Constipation?	□ Y	□N
Any Diarrhea?	□ Y	□N