MALE INTAKE HISTORY

Patient Name:____ **Date of Birth:**____________________

Current Concern(s)

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____
____
____
____

Current Medications

____
____
____
____
____
____

Allergies

____
____
____
____
____
____

Health Care Maintenance (Please list date of last procedure and result if known)
Colonoscopy: ____
Dexascan: ____
Lipid Profile (Cholesterol): ____

Current Supplements

____
____
____
____
____

Social History
Smoking: _____ No _____ Yes packs per day:________ # years of use: _________
Alcohol : _____ No _____ Yes drinks per day:________ drinks per week:_ _______
Illicit Drugs: _____ No _____ Yes type:________________ frequency: _____________
Marital Status: ________single _______ married _______ divorced _______ widowed
School Completed: _____ high school _____ college _____ graduate _____ other___________
Occupation: _____________________________ Hobbies: ______________________________
Abuse History: _______ physical _______ sexual _______ verbal / emotional

Past Medical History

Arthritis	Diabetes	Psoriasis
Asthma	Eczema	Kidney Disease
Alzheimer's Disease	Drug Addiction/Alcoholism	Stroke
Autoimmune (MS, Lupus, etc)	Heart disease	Thyroid Issues
Cancer	High Blood Pressure	Mental Illness
Depression	Migraine headaches	Other ___________________

Surgical, Injury and Hospitalization History

Please list all surgeries, injuries and hospitalizations and the dates on which they occured.

____
____
____
____
____

Family History

Mom: _____ alive - current age: _____ _____deceased - age of death: _____ cause: ________________

Dad: _____ alive - current age: _____ _____deceased - age of death: _____ cause: ________________

Siblings:

_____ alive - current age: _____ _____deceased - age of death: _____ cause: ________________

_____ alive - current age: _____ _____deceased - age of death: _____ cause: ________________

Illnesses:			**Who? Deceased?**
High Blood Pressure	_____ No	_____ Yes	____
Diabetes	_____ No	_____ Yes	____
Heart Disease	_____ No	_____ Yes	____
Osteoporosis	_____ No	_____ Yes	____
Cancer	_____ No	_____ Yes	____
Stroke	_____ No	_____ Yes	____

Other?____

Review of Systems

1.) Constitutional:

weight changes ________No ________Yes ____

fatigue ________No ________Yes ____

2.) Skin/Breast:

pain or mass in breast ________No ________Yes ____

nipple discharge ________No ________Yes ____

skin lesion ________No ________Yes ____

3.) Eyes:

vision problems ________No ________Yes ____

4.) ENT/Mouth:

hearing problems ________No ________Yes ____

sinus problems ________No ________Yes ____

dental problems ________No ________Yes ____

5.) Cardiovascular:

chest pain/shortness of breath ________No ________Yes ____

swelling in legs ________No ________Yes ____

palpitations of heart ________No ________Yes ____

6.) Respiratory:

wheezing or cough ________No ________Yes ____

7.) Gastrointestional:

nausea or vomiting ________No ________Yes ____

diarrhea or constipation ________No ________Yes ____

blood in stool ________No ________Yes ____

8.) Urinary:

pain with urination ________No ________Yes ____

blood in urine ________No ________Yes ____

incontinence ________No ________Yes ____

9.) Hematological:

frequent bruising ________No ________Yes ____

cuts do not stop bleeding ________No ________Yes ____

enlarged lymph nodes ________No ________Yes ____

10.) Psychiatric:

depression ________No ________Yes ____

anxiety ________No ________Yes ____

Exercise (Please check all that apply)

No formal exercise
5-7 days per week
3-4 days per week
1-2 days per week

45 minutes or more duration per workout
30-45 minutes duration per workout
less than 30 minutes duration per workout
Walk
Run, jog, jump rope
Weight train
Yoga
Aerobic
Other ____________________

Sleep (Please check all that apply)

8-10 hours per night
6-8 hours per night
Less than 6 hours per night

Undisturbed sleep
Difficulty falling asleep
Difficulty staying asleep

Wake feeling rested
Wake feeling tired

Signature of Patient: ____ **Date:** _____/_____/_____

Reviewed by Physician:

Date: _____/_____/_____ **Physician Signature:** ____