SOUTH BAY TOTAL HEALTH *Please fill out and return*

MALE HEALTH STATUS INTERVIEW

version 11-17-2007

Patient Note: This is a confidential record of your medical history. It will not be released except when you have authorized us to do so.

Successful health care and preventive medicine are only possible when the doctor has a thorough understanding of your health — physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Mark anything you do not understand with a question mark. Thank you.

Last Name:_____ First Name:_____ MI:_____ Today's Date: _____

Date of Birth: _____ Age: _____ Gender: M F

Your Occupation: _____ Number of hours per week: _____

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partnership

Name of Spouse/Significant Other: _____

Are you receiving health care anywhere else? Yes / No

If yes where and from whom?_____

_____

_____

Chief Complaints: List your health concerns in order of their importance to you. Please include dates of onset.

1._____

_____

2. _____

_____

3. _____

_____

4. _____

_____

5. _____

_____

6. _____

_____

7. _____

_____

8. _____

_____

Allergies

To any drugs? _____

To any foods? _____

To any environmental pollens/grasses? _____

Other? _____

Surgeries: List the type and year of any surgeries:

_____

_____

_____

Hospitalizations: List any other hospitalizations and the reason:

_____

_____

_____

List all the **medications** that you are currently taking, including dosage

Be sure to include things such as: Laxatives, Cortisone, Tranquilizers, Pain Reliever, Appetite suppressants, Thyroid medications, Antacids, Antibiotics, Sleeping pills, Birth Control Pills, water pills, hormone replacement, blood pressure medications and any other prescription medications:

_____

_____

_____

_____

_____

_____

List all **vitamins, minerals, herbs, homeopathic remedies and nutritional supplements** you are currently taking:

_____

_____

_____

_____

_____

_____

_____

Personal Habits:

Do you eat three meals per day? YES NO
How many hours of sleep each night? _____
Do you wake feeling rested? YES NO
Do you spend time outside? YES NO
Do you have a supportive relationship? YES NO
Do you take vacations? YES NO
Have you had any major traumas? YES NO
Do you have a history of abuse? YES NO
(physical, emotional or sexual)
Do you drink coffee? YES NO
Do you drink black tea? YES NO
Do you drink sodas or energy drinks? YES NO
Do you consume sugar? YES NO

Do you consume alcohol? YES NO
Beer Wine Spirits
Number of drinks per day/week/month _____
Do you smoke? YES NO
Current Past
Yr started _____ Yr stopped _____
Recreational drug use? YES NO PAST
amphetamines barbituates narcotics
heroin cocaine marijuana
other_____
Religious or spiritual practice? YES NO
Do you enjoy your job? YES NO
Do you watch TV? YES NO hrs per week_____
Do you read? ? YES NO hrs per week_____

Typical Daily Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

How much/often do you consume of the following?

☐ soda or carbonated beverages	NEVER	RARELY	SOMETIMES	FREQUENT
☐ white flour products	NEVER	RARELY	SOMETIMES	FREQUENT
☐ fried foods	NEVER	RARELY	SOMETIMES	FREQUENT
☐ raw foods	NEVER	RARELY	SOMETIMES	FREQUENT
☐ refined sugar	NEVER	RARELY	SOMETIMES	FREQUENT
☐ red meat or pork	NEVER	RARELY	SOMETIMES	FREQUENT
☐ tap water	NEVER	RARELY	SOMETIMES	FREQUENT
☐ fresh vegetables	NEVER	RARELY	SOMETIMES	FREQUENT
☐ fresh fruit	NEVER	RARELY	SOMETIMES	FREQUENT
☐ pure water (eg. bottled)	NEVER	RARELY	SOMETIMES	FREQUENT
☐ cook with shortening or oils other than coconut oil	NEVER	RARELY	SOMETIMES	FREQUENT
☐ margarine	NEVER	RARELY	SOMETIMES	FREQUENT
☐ green leafy vegetables (spinach, salad, etc)	NEVER	RARELY	SOMETIMES	FREQUENT
☐ sweets/deserts	NEVER	RARELY	SOMETIMES	FREQUENT
☐ candy	NEVER	RARELY	SOMETIMES	FREQUENT

Current Metabolic Status: Please indicate your present state for each of the following items

Sleep. usual bedtime, hours slept, problems with falling asleep or waking up after your fall asleep. dreams and or nightmares

_____

_____

_____

Energy Level when waking up, throughout the day.

_____

_____

_____

Bowel Movements. frequency (number per day), quality of stools (small and hard, loose, etc.)

_____

_____

Urination. approximate number of times per day, waking up at night to urinate, pain or other symptoms during urination, etc.

_____

_____

_____

Perspiration. do you perspire excessively during the day or at night. do you NOT perspire when it would be appropriate to do so (for example, during exercise)

_____

_____

_____

Exercise
How often do you exercise and what type of exercise?

_____

_____

Do you experience any symptoms during exercise (pain in any particular place in your body, shortness of breath, extreme fatigue beyond what is normal for the activity, heart palpitations, dizziness, abnormally high or low perspiration, etc.)?

_____

_____

_____

If you know your blood type, please tell us: _____

Weight _____ Weight 1 year ago _____ Maximum Weight _____ when? _____

What do you think should be your desired weight _____ Height _____

Personal Medical History: Please circle any of the following conditions/symptoms you have had, **Yes**-I have this now; **Never**-I've never had it; **Past**-I've had it in the past but not now.

Head

Headaches?	YES	NEVER	PAST	Head injury or trauma?	YES	NEVER	PAST
Migraines?	YES	NEVER	PAST	Concussion?	YES	NEVER	PAST
Lightheadedness?	YES	NEVER	PAST	Loss of balance?	YES	NEVER	PAST
Dizziness?	YES	NEVER	PAST	Jaw/TMJ problems?	YES	NEVER	PAST
Bell's Palsy?	YES	NEVER	PAST	Other? _____			

Eyes

Spots in Eyes?	YES	NEVER	PAST	Cataracts?	YES	NEVER	PAST
Impaired vision?	YES	NEVER	PAST	Glasses/Contacts?	YES	NEVER	PAST
Blurriness?	YES	NEVER	PAST	Tearing or dryness?	YES	NEVER	PAST
Color blindness?	YES	NEVER	PAST	Glaucoma?	YES	NEVER	PAST
Double Vision?	YES	NEVER	PAST	Night Blindness?	YES	NEVER	PAST
Eye Pain?	YES	NEVER	PAST	Circles under eyes?	YES	NEVER	PAST
Swollen Eyes?	YES	NEVER	PAST	Other? _____			
Eyestrain?	YES	NEVER	PAST				

Ears

Impaired hearing?	YES	NEVER	PAST	Ringing in ears?	YES	NEVER	PAST
Deafness?	YES	NEVER	PAST	Excessive ear wax?	YES	NEVER	PAST
Earaches?	YES	NEVER	PAST	Frequent ear infections?	YES	NEVER	PAST
Itching of ears?	YES	NEVER	PAST	Other? _____			

Nose & Sinuses

Frequent Colds?	YES	NEVER	PAST	Nose Bleeds?	YES	NEVER	PAST
Stuffiness?	YES	NEVER	PAST	Sinus Problems?	YES	NEVER	PAST
Post Nasal Drips?	YES	NEVER	PAST	Hayfever?	YES	NEVER	PAST
Loss of Smell?	YES	NEVER	PAST	Allergies?	YES	NEVER	PAST
Bell's Palsy?	YES	NEVER	PAST	Polyps?	YES	NEVER	PAST
				Other? _____			

Mouth & Throat

Frequent sore throat?	YES	NEVER	PAST	Sore Tongue?	YES	NEVER	PAST
Sores in mouth?	YES	NEVER	PAST	Gum problems?	YES	NEVER	PAST
Hoarseness?	YES	NEVER	PAST	Dental Problems?	YES	NEVER	PAST
Difficulty Swallowing?	YES	NEVER	PAST	Difficulty Speaking?	YES	NEVER	PAST
Loss of Taste?	YES	NEVER	PAST	Dental Cavities?	YES	NEVER	PAST
Teeth Grinding?	YES	NEVER	PAST	Jaw Clicks?	YES	NEVER	PAST
Sore Lips?	YES	NEVER	PAST	Copious Saliva?	YES	NEVER	PAST
Enlarged lymph nodes	YES	NEVER	PAST	Dry Mouth?	YES	NEVER	PAST
				Other? _____			

Respiratory

Coughing?	YES	NEVER	PAST	Sputum?	YES	NEVER	PAST
Spitting up blood?	YES	NEVER	PAST	Bronchitis?	YES	NEVER	PAST
Wheezing?	YES	NEVER	PAST	Pleurisy?	YES	NEVER	PAST
Difficulty breathing?	YES	NEVER	PAST	Emphysema?	YES	NEVER	PAST
Pain with breathing?	YES	NEVER	PAST	Pneumonia?	YES	NEVER	PAST
Shortness of breath?	YES	NEVER	PAST	Asthma?	YES	NEVER	PAST
- while lying down?	YES	NEVER	PAST	Positive TB Test?	YES	NEVER	PAST
- at night?	YES	NEVER	PAST	Other? _____			

Cardiovascular

Heart disease?	YES	NEVER	PAST	Angina?	YES	NEVER	PAST
High/Low blood pressure?	YES	NEVER	PAST	Heart murmurs?	YES	NEVER	PAST
Blood Clots?	YES	NEVER	PAST	Fainting?	YES	NEVER	PAST
Phlebitis?	YES	NEVER	PAST	Palpitations?	YES	NEVER	PAST
Rheumatic Fever?	YES	NEVER	PAST	Heart Flutters?	YES	NEVER	PAST
Swelling in ankles?	YES	NEVER	PAST	Chest Pain?	YES	NEVER	PAST
Bleeding/clotting disorder?	YES	NEVER	PAST	Stroke?	YES	NEVER	PAST
High cholesterol?	YES	NEVER	PAST	Heart attack?	YES	NEVER	PAST
Atherosclerosis?	YES	NEVER	PAST	Other? _____			

Circulation

Cold hands/feet?	YES	NEVER	PAST	Varicose veins?	YES	NEVER	PAST
Deep leg pain?	YES	NEVER	PAST	Anemia?	YES	NEVER	PAST
Easy bleeding/bruising?	YES	NEVER	PAST	Thrombophlebitis?	YES	NEVER	PAST
				Other? _____			

Urinary

Pain during urination?	YES	NEVER	PAST	Increased frequency?	YES	NEVER	PAST
Frequency at night?	YES	NEVER	PAST	Unable to hold urine?	YES	NEVER	PAST
Bladder infections?	YES	NEVER	PAST	Kidney stones?	YES	NEVER	PAST
Unable to urinate?	YES	NEVER	PAST	Blood in urine?	YES	NEVER	PAST
				Other? _____			

Gastrointestinal

Trouble swallowing?	YES	NEVER	PAST	Liver disease?	YES	NEVER	PAST
Jaundice?	YES	NEVER	PAST	Hepatitis?	YES	NEVER	PAST
Nausea?	YES	NEVER	PAST	Heartburn?	YES	NEVER	PAST
Vomiting blood?	YES	NEVER	PAST	Acid Reflux?	YES	NEVER	PAST
Blood in stool?	YES	NEVER	PAST	Change in appetite?	YES	NEVER	PAST
Abdominal pain/cramps?	YES	NEVER	PAST	Vomiting?	YES	NEVER	PAST
Belching or passing gas?	YES	NEVER	PAST	Diarrhea?	YES	NEVER	PAST
Gallbladder disease?	YES	NEVER	PAST	Constipation?	YES	NEVER	PAST
Ulcers?	YES	NEVER	PAST	Bloating?	YES	NEVER	PAST
Stomach pain?	YES	NEVER	PAST	Hemorrhoids?	YES	NEVER	PAST
Black Stools?	YES	NEVER	PAST	Change in thirst?	YES	NEVER	PAST
Diverticulitis/losis?	YES	NEVER	PAST	Colitis?	YES	NEVER	PAST
Crohn's disease?	YES	NEVER	PAST	Hiatal Hernia?	YES	NEVER	PAST
Irritable Bowel Syndrome?	YES	NEVER	PAST	Other? _____			

Skin

Rashes?	YES	NEVER	PAST	Eczema?	YES	NEVER	PAST
Hives?	YES	NEVER	PAST	Psoriasis?	YES	NEVER	PAST
Acne, boils?	YES	NEVER	PAST	Itching?	YES	NEVER	PAST
Color changes?	YES	NEVER	PAST	Dryness?	YES	NEVER	PAST
Lumps?	YES	NEVER	PAST	Perpetual hair loss?	YES	NEVER	PAST
Ulceration?	YES	NEVER	PAST	Night sweats?	YES	NEVER	PAST
Shingles?	YES	NEVER	PAST	change in hair/nails?	YES	NEVER	PAST
Sores?	YES	NEVER	PAST	Other? _____			
Infections?	YES	NEVER	PAST				

Neck

Pain or stiffness?	YES	NEVER	PAST	Lumps?	YES	NEVER	PAST
Swollen Glands?	YES	NEVER	PAST	Herniated disk?	YES	NEVER	PAST
Pinched nerve?	YES	NEVER	PAST	Other? _____			

Musculoskeletal

Joint pain or stiffness?	YES	NEVER	PAST	Osteopenia?	YES	NEVER	PAST
Muscle spasms?	YES	NEVER	PAST	Broken Bones?	YES	NEVER	PAST
Muscle weakness?	YES	NEVER	PAST	Back Pain?	YES	NEVER	PAST
Arthritis?	YES	NEVER	PAST	Herniated disk?	YES	NEVER	PAST
Bursitis?	YES	NEVER	PAST	Back surgery?	YES	NEVER	PAST
Osteoporosis?	YES	NEVER	PAST	Other? _____			

Neurological

Seizures?	YES	NEVER	PAST	Paralysis?	YES	NEVER	PAST
Muscle weakness?	YES	NEVER	PAST	Numbness or tingling?	YES	NEVER	PAST
Loss of memory?	YES	NEVER	PAST	Loss of balance?	YES	NEVER	PAST
Vertigo?	YES	NEVER	PAST	Lightheaded?	YES	NEVER	PAST
Dizziness?	YES	NEVER	PAST	Poor concentration?	YES	NEVER	PAST
Trembling hands/feet?	YES	NEVER	PAST	Slurred Speech?	YES	NEVER	PAST
Mood swings?	YES	NEVER	PAST	Neuralgia?	YES	NEVER	PAST
Epilepsy?	YES	NEVER	PAST	Loss of Coordination?	YES	NEVER	PAST
Easily stressed?	YES	NEVER	PAST	Other? _____			

Mental / Emotional

Excess Stress?	YES	NEVER	PAST	Suicidal thoughts?	YES	NEVER	PAST
Anxiety?	YES	NEVER	PAST	Treated for emotions?	YES	NEVER	PAST
Panic Attacks?	YES	NEVER	PAST	Nervousness?	YES	NEVER	PAST
Depression?	YES	NEVER	PAST	Seasonal depression?	YES	NEVER	PAST
Mood swings?	YES	NEVER	PAST	Other? _____			
Memory loss?	YES	NEVER	PAST				

Endocrine

Hypothyroid?	YES	NEVER	PAST	Heat or cold intolerance?	YES	NEVER	PAST
Hyperthyroid?	YES	NEVER	PAST	Diabetes?	YES	NEVER	PAST
Hypoglycemia?	YES	NEVER	PAST	Excessive hunger?	YES	NEVER	PAST
Excessive thirst?	YES	NEVER	PAST	Seasonal depression?	YES	NEVER	PAST
Unexplained weight loss?	YES	NEVER	PAST	Easy weight gain?	YES	NEVER	PAST
Poor appetite?	YES	NEVER	PAST	Pituitary disorder?	YES	NEVER	PAST
Fatigue?	YES	NEVER	PAST	Adrenal problem?	YES	NEVER	PAST
Hormonal problems?	YES	NEVER	PAST	Other? _____			

Immune

Slow wound healing?	YES	NEVER	PAST	Reaction to vaccinations?	YES	NEVER	PAST
Chronic fatigue synd.?	YES	NEVER	PAST	Chronic infections?	YES	NEVER	PAST
Chronic swollen glands?	YES	NEVER	PAST	Cancer?	YES	NEVER	PAST
				Other? _____			

Infectious Illnesses

Scarlet Fever?	YES	NEVER	PAST	Mumps?	YES	NEVER	PAST
Diphtheria?	YES	NEVER	PAST	Measles?	YES	NEVER	PAST
Rheumatic Fever?	YES	NEVER	PAST	Polio?	YES	NEVER	PAST
Chicken Pox?	YES	NEVER	PAST	Meningitis?	YES	NEVER	PAST
German Measles?	YES	NEVER	PAST	Epstein-Barr?	YES	NEVER	PAST
				Other? _____			

Male Genitourinary System

Urinary Frequency?	YES	NEVER	PAST	pain or sores on penis?	YES	NEVER	PAST
Urging without passing?				discharge from penis?	YES	NEVER	PAST
urine	YES	NEVER	PAST	hernias?	YES	NEVER	PAST
Waking during night to?				testicular pain?	YES	NEVER	PAST
urinate	YES	NEVER	PAST	testicular swelling?	YES	NEVER	PAST
Pain/burning	YES	NEVER	PAST	lumps on testicles, ?			
trouble starting urine?	YES	NEVER	PAST	scrotum or penis	YES	NEVER	PAST
cloudy urine?	YES	NEVER	PAST	inability to achieve or			
red-tinged/blood urine?	YES	NEVER	PAST	maintain an erection?	YES	NEVER	PAST
foul-smelling urine?	YES	NEVER	PAST	premature ejaculation?	YES	NEVER	PAST
Prostate Cancer?	YES	NEVER	PAST	surgery of prostate,			
BPH?	YES	NEVER	PAST	genitals, hernia,			
testicular cancer?	YES	NEVER	PAST	vasectomy?	YES	NEVER	PAST
penile cancer?	YES	NEVER	PAST	Other? _____			

Sexually Transmitted diseases? **YES** **NO**

herpes, venereal warts, gonorrhea, syphillis, chlamydia, chancre, HIV/AIDS other

Have any male members of your family had

____ Prostate Cancer ____ Enlarged Prostate ____ Testicular Cancer If so, who? _____

Date of your last prostate exam _____

Ever have abnormal findings on a prostate exam **YES** **NO** _____

Sexual History

Are you currently sexually active? **YES** **NO** With men, women or both? _____

Do you have multiple partners? **YES** **NO**

Do you experience pain or discomfort during sex? **YES** **NO**

Do you use condoms or other birth control methods? **YES** **NO** _____

Your Childhood History: To the best of your memory, please provide the following information about YOUR childhood

Age of your mother when you were born: _____
Number of her previous pregnancies:_____
Indicate any medical problems your mother had while pregnant with you?

_____

_____

Did your mother take any medications during pregnancy:

_____

Did she use Alcohol or Tobacco while pregnant with you or while nursing? Y N

Does your mother have any allergies: _____

_____

Were you breastfed as a child and if so, how long?

_____

What vaccinations did you receive as a child and at what ages?

MMR:_____ Hepatitis B _____
Polio _____ Tetanus booster _____
Hepatitis A_____ Varicella_____
DPT:_____ Other_____
Hib_____

Did your parents note any adverse reactions to vaccinations or illnesses around the time you received them?

_____

During each of the following age periods, 1) where did you live, 2) what illnesses did you have?
- birth to 2 years

_____

- 2 years to 5 years

_____

- 5 years to puberty

_____

- puberty through roughly age 20

_____

_____

Family Medical History:

	Father	Mother	Brothers			Sisters			Other Relatives		
			1	2	3	1	2	3			
Age (if living)											
Cancer											
Diabetes											
Heart trouble											
High Blood Pressure											
Stroke											
Epilepsy											
Mental Disorders											
Asthma											
Allergies											
Other Conditions											
Age at death											
Cause of Death											

Hobbies & Interests

Hobbies & Interests: _____

What do you enjoy doing the most? _____

How often do you do the above activities? _____

Your Opinions About Your Health

How does your condition affect you? _____

_____

_____

What do you think is happening; why do you think you have this condition? _____

_____

What do you feel needs to happen for you to get better? _____

_____

_____

Is there any additional information you would like to add? _____

_____

How much change are you willing to make at this time for improving your health?

circle one: **MINIMAL** **SOME** **COMPLETE**

FORM COMPLETE!

Welcome to South Bay Total Health