Consults in Wellness, PLLC

MALE HEALTH HISTORY

Today's Date: __________

Name: ____ **Age:** ______ **Birth Date:** ______________

What is your Blood Type? A pos A neg B pos B neg AB pos AB neg O pos O neg I don't know

What are your major concerns? ____

____

____

Please list any medical problems that you are currently being treated for or have been treated for in the past:

____ ____

____ ____

____ ____

____ ____

Please list any surgeries including dates or year: ____

____ ____

____ ____

____ ____

Please list any allergies you have to food or medications: ____

____

Please list any medications, nutritional supplements ***with dosages***, prescription or over-the-counter, that you take:
(or Attach a typed list) *Bring all meds and supplement bottles to your first visit*

____ ____

____ ____

____ ____

____ ____

____ ____

Family History: Do your parents (M, F) grandparents (MGM, MGF, PGM, PGF), brothers (B), or sisters (S) or children (C) have any of the following? (**put abbreviation in blank by condition and approx age diagnosed)

Heart Attack ______________ Heart disease/ Heart Surgery ______________ Diabetes ______________
Stroke ____________ Aneurysm _____________High Cholesterol _____________Clots______________
High Blood Pressure ______________Thyroid Disease ______________Mental Illness______________
Autoimmune Diseases (ex – rheumatoid arthritis, lupus, celiac, MS, psoriasis, etc) ____________________
Cancer If yes, list what type(s)? ____

Preventive Care:

Date of last PSA (prostate test) _______ Result: ________ Date of last prostate exam? _______ Result: ______
Date of last sigmoidoscopy/colonoscopy: _________ Result: _________ Did you have polyps? ___________ _______ _______
Date of last bone density study (if applicable) ________ Result: _________
Do you have regular: Dental visits? YES NO Last visit ____ Derm/ skin exams? YES NO Last visit ____

HRT:

Do you OR have you used hormone replacement therapy (HRT)? YES NO I am currently using HRT
If yes, what form(s) of HRT have you used in the past? ____

Have you had a vasectomy? YES NO If yes, when? ____________________________
Are you sexually active? YES NO With males, females, or both? _____________________
Have you had prostate problems? YES NO Explain ____

____

Name: ____ **Age:** ______ **Birth Date:** ______________

Lifestyle and Health Habits:

Average hours of sleep per night	<4	4-6	>7
General energy level	Low	Comes & goes	Normal
Overall Stress Level	High	Average	Low
Manage stress	Poorly	Okay	Well
Work (employment)	<8 hours/day avg	8 hours/day	>8 hours/day
Enjoy work	Never/Rarely	Sometimes	Often/Always
Floss teeth	Never/rarely	Occasionally	Frequently/daily
Drink Filtered/bottled water	Never/rarely	Occasionally	Frequently/daily
Practice Meditation	Never	A few times a week	Daily/Regularly

Do you have a consistent or fairly consistent exercise routine? YES NO
What types of exercise activities do you enjoy ? ____
How often?____________________ What duration? ____________

Do you smoke cigarettes? YES NO If yes, # per day: ___________ Number of years: ___________
Previous smoker? YES NO Stop date: __________ # per day: __________ # of years: ___________

How much water do you drink daily? <1-2 glasses/ < 8-16 oz 20-40 oz > 40-60 oz
What other fluids do you drink besides water? ____
Do you drink caffeine products? YES NO What types? _________________ Amounts? _________________
Do you consume artificial sweeteners (ex – Splenda, Sweet&Low, Nutrasweet) YES NO. How much? __________________
What foods/drink do you add sugar or have sugar to at home or eating out? ____

Do you drink alcohol? YES NO I rarely drink If yes, do you drink alcohol most days of the week? YES NO
What type of alcohol do you consume? ___________________ How much at once ? ___________________

Nutrition Habits

Are you a vegetarian? YES NO Are you a vegan? YES NO

Do you avoid or eliminate foods, food groups or types? ____

Meat consumption – POULTRY	Frequently/Daily	Occasionally	Never
Meat consumption - PORK	Frequently/Daily	Occasionally	Never
Meat consumption – BEEF	Frequently/Daily	Occasionally	Never
Meat consumption – FISH	Frequently/Daily	Occasionally	Never
Egg consumption	Frequently/Daily	Occasionally	Never
Yogurt consumption	Frequently/Daily	Occasionally	Never
Dairy (milk, cheese)	Frequently/Daily	Occasionally	Never
Nuts (other than peanuts)	Frequently/Daily	Occasionally	Never
Soy or soy products	Frequently/Daily	Occasionally	Never
Serving of fresh vegetables daily	0-1	2-5	>5
Servings of fresh fruit daily	0-1	2-5	>5
Eat a good breakfast	Frequently/Daily	Occasionally	Never
Percentage of food wrapped or packaged	<10%	10-50%	> 50%
Cakes, cookies, pastries	Frequently/Daily	Occasionally	Never
Whole Grains	Frequently/Daily	Occasionally	Never

Name 5-6 vegetables you regularly consume: ____

____
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What specific foods do you eat almost daily or most days of the week? .____