THE MEN'S CLINIC - MADISON

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MADISON, MS

PERSONAL HEALTH HISTORY FORM

PERSONAL HEALTH HISTORY

To determine your present state of health, please circle yes or no as it applies to each condition or question.

1. Headaches (migraine, cluster, tension): **yes** or **no**
2. Neurological disorder (epilepsy, seizure, stroke): **yes** or **no**
3. Lung disorders (asthma, pneumonia, emphysema): **yes** or **no**
4. Heart disease (angina, heart failure, heart attack, stroke): **yes** or **no**
5. Hypertension (high blood pressure): **yes** or **no**
6. Hyperlipidemia (high cholesterol): **yes** or **no**
7. Peptic ulcer / reflux esophagitis / pancreatitis: **yes** or **no**
8. Irritable bowel disease / Crohn's disease: **yes** or **no**
9. Liver or gall bladder disease: **yes** or **no**
10. Edema or excess fluid retention: **yes** or **no**
11. Insulin resistance or diabetes: **yes** or **no**
12. Thyroid disease: **yes** or **no**
13. Other hormonal deficiencies including growth hormone: **yes** or **no**
14. History of cancer?.... if yes, what type(s) of cancer, date(s), treatment type(s)

_____

_____

_____

15. Arthritis or joint problems including herniated disc: **yes** or **no**
16. Osteoporosis: **yes** or **no**
17. Have you had any other medical problems that have been diagnosed by other healthcare professionals (describe):

_____

_____

_____

_____

Have you recently experienced any of the following, please mark YES or NO as it applies to each condition.

18. Loss of concentration, sociability, activity: **yes** or **no**
19. Decreased short or long-term memory: **yes** or **no**
20. Decreasing desire or ability to exercise: **yes** or **no**
21. Decreasing sense of well-being: **yes** or **no**
22. Loss of interest in/or desire for sex: **yes** or **no**
23. Cold or heat intolerance: **yes** or **no**
24. Indigestion or difficulty swallowing: **yes** or **no**
25. Stomach pain: **yes** or **no**
26. Belching: **yes** or **no**
27. Heartburn: **yes** or **no**
28. Bloating after meals: **yes** or **no**
29. Brittle nails: **yes** or **no**
30. Dry skin: **yes** or **no**
31. Hair loss: **yes** or **no**
32. Chest pains: **yes** or **no**
33. Palpitations: **yes** or **no**
34. Swelling of ankles: **yes** or **no**
35. Easily tired: **yes** or **no**
36. Night sweating: **yes** or **no**
37. Unusual or excess sweating: **yes** or **no**
38. Difficulty breathing: **yes** or **no**
39. Have you had any surgeries (describe)

_____
_____
_____
_____
_____

40. Have you had any other hospitalizations?

_____
_____
_____

41. Have you ever had a blood transfusion? **yes** or **no**
42. Do you take any prescribed or over-the-counter drugs? **yes** or **no**

(if yes, please list below):

_____
_____
_____

43. Are you allergic to any medications? (if yes, please list below) **yes** or **no**

_____

_____

_____

44. Are you currently dieting to lose weight or for other health reasons? **yes** or **no**

45. If you answered yes above, are you on a diet prescribed by a health care professional?**yes** or **no**

46. Do you use recreational drugs? **yes** or **no**

47. If you answered yes above, have you ever received recreational drugs with a needle? **yes** or **no**

48. Do you currently use tobacco products (cigarettes, cigars, pipe, chew, etc.)? **yes** or **no**

49. How many times per day do you consume caffeine (one cup of coffee or tea, one can of soda)?

__ One __ Two __Three __ Four or more

50. How many times per week do you consume alcohol (one glass of wine, one cocktail, one beer)?

__One __Two __Three __Four __Five __Six __Seven or more

51. How much do you exercise, please mark below as it applies to frequency:

___ Never (i.e. no exercise or physical activity)

___ Rarely (i.e. climb stairs, walk 3 blocks, golf)

___ Occasionally (, i.e. less than 4x/week for 30 min)

___ Regularly (i.e. 4x/week for 30 mins)

FAMILY HEALTH HISTORY

Do you have a first degree relative who has been diagnosed with cancer? **___yes ___no**

If so, what type?

_____

_____

_____