

Center for Hormonal Wellness

HEALTH HISTORY QUESTIONNAIRE

Original Date:
Dates Revised:

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.):	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
		Date of last physical exam:

PERSONAL HEALTH HISTORY

Childhood illness:	<input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio				
Immunizations and dates:	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia			
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chickenpox			
	<input type="checkbox"/> Influenza	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>			

List any medical problems that other doctors have diagnosed

--

Surgeries		
Year	Reason	Hospital

Other hospitalizations		
Year	Reason	Hospital

Have you ever had a blood transfusion?	<input type="checkbox"/> Yes <input type="checkbox"/> No
--	--

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Diet	Are you dieting?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Rank salt intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
Caffeine	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola		
	# of cups/cans per day?		
Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you considered stopping?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever experienced blackouts?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you prone to "binge" drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you drive after drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	
Drugs	Do you currently use recreational or street drugs?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?		<input type="checkbox"/> Yes <input type="checkbox"/> No

Erectile dysfunction questionnaire

	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Are you sexually active?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you take nitroglycerine for chest pain pressure or any nitroglycerine containing medication	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you taken Viagra or Cialis or similar medication before	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Any side effects from Viagra or Cialis or similar medication before	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
IF YES please explain _____				
History of Melanoma	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Any issue with the shape of your penis, (bent, broken, lumps or bumps) PYRONIE'S DISEASE	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Are you able to walk for 20 minutes without having shortness of breath	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Are you able to climb 2 flight of stairs without shortness of breath	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Ever been told you are not healthy enough to have sex	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you ever been diagnosed with high blood pressure	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you ever been diagnosed with low blood pressure	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you ever experienced episodes of lightheadedness or dizziness	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you ever had chest pain or pressure and shortness of breath with any activity	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you have any heart condition, fast or slow heart rate or irregular heartbeat	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you have premature ejaculation (come or ejaculate short time after sex)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Did your erection problem started suddenly	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you had physical exam by a licensed health care provided last 24 months	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you ever been diagnosed of having low Testosterone	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you have any other heart conditions	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M	
				<input type="checkbox"/> F	
Mother				<input type="checkbox"/> M	
			<input type="checkbox"/> F		
Sibling	<input type="checkbox"/> M		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		Grandmother		
	<input type="checkbox"/> F		<i>Maternal</i>		
	<input type="checkbox"/> M		Grandfather		
	<input type="checkbox"/> F		<i>Maternal</i>		
	<input type="checkbox"/> M		Grandmother		
	<input type="checkbox"/> F		<i>Paternal</i>		
	<input type="checkbox"/> M		Grandfather		
	<input type="checkbox"/> F		<i>Paternal</i>		

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

MEN ONLY

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam?		

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

Print your Name _____

Date _____

Sign _____