Dr. Barbara Jennings
Natural Health In Real Life

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MALE HEALTH HISTORY QUESTIONNAIRE

GENERAL INFORMATION

Name: Today's Date:

Address _____ Phone # (h) _____ (c) _____

_____ Email Address _____

_____ Age _____ Date of Birth _____

Height _____ Weight _____ Occupation _____

COMPLAINTS/CONCERNS

Please list your chief symptoms in order of decreasing severity, starting with the worst one. Please note how long each symptom has been present.

Problem	Onset	Frequency	Severity
1. e.g. Headaches	June 2007	4 times per week	Mild / moderate / severe
2.			
3.			
4.			
5.			
6.			
7.			

ALLERGIES

Medication/Supplement/Food	Reaction

IMMUNIZATION HISTORY

Have you received any vaccinations in the last 5 years? Yes ____ No ____ If yes, please list: _____

_____

DENTAL HISTORY

Do you currently have any amalgam, silver, metal, and/or gold fillings? Yes ____ No ____ If yes, how many? _____

If yes, please list which kinds: _____

How long have you had these fillings? _____

If you do not have any fillings in your mouth, have you had any fillings removed in the last 12 months? Yes ____ No ____

Have you had any dental work done in the last 12 months? Yes ____ No ____

MEDICATIONS AND SUPPLEMENTS

Medications: Please list any medications that you are currently taking or have taken in the last month, including antibiotics, non-prescription drugs, and prescription drugs.

Medication Name	Dosage

Supplements: List all vitamins, minerals and other nutritional supplements that you are currently taking.

Supplement Name/Brand	Dosage

Have your medications or supplements ever caused you unusual side effects or problems?

Yes _____ No _____ If yes, please describe: _____

SLEEP/REST

Average number of hours you sleep ☐ > 10 ☐ 8 – 10 ☐ 6 – 8 ☐ < 6

Do you have trouble falling asleep? Yes ____ No ____

Do you rested upon awakening? Yes ____ No ____

Do you have problems with insomnia? Yes ____ No ____

Do you snore? Yes ____ No ____ Explain: _____

LIFESTYLE INDICATORS

TOBACCO HISTORY

Currently using tobacco? Yes ____ No ____ How many years? _____ Packs per day: _____

If yes, what type? Cigarette _____ Smokeless _____ Cigar _____ Pipe _____ Patch/Gum _____

Previous smoking: How many years? _____ Packs per day: _____

Are you exposed to 2nd hand smoke? If yes, please explain: _____

ALCOHOL INTAKE

How many drinks currently per week? *1 drink = 5 oz wine, 12oz beer, 1.5 oz spirits*

None _____ 1 – 3 _____ 4 – 6 _____ 7 – 10 _____ > 10 _____

Previous alcohol intake? Yes _____ (Mild _____ Moderate _____ High _____)

CAFFEINE INTAKE

How many cups of coffee per day? None _____ 1 – 3 _____ 4 – 6 _____ 7 – 10 _____

How many cans of soda per day? None _____ 1 – 3 _____ 4 – 6 _____ 7 – 10 _____

Is the soda you drink, diet soda? Yes _____ No _____

SYMPTOMS

Symptoms	Mild	Moderate	Severe	Additional Comments
Body/joint aches				
Weight gain				
Weight loss				
Elevated blood pressure				
Elevated cholesterol				
Digestive problems				
Head hair loss				
Dry skin/thinning skin				
Constant hunger				
Sweet cravings				
Caffeine craving				
Salt cravings				
Anger/Aggression				
Irritibality				
Low mood/Depression				
Concentration problems				
Foggy thinking				
Increased fatigue				
Lowered libido				
Erectile dysfunction				
Frequent need to urinate				
Pain with urination				
Bone loss/osteoporosis				
Low blood sugar				
Other				

MISCELLANEOUS

Have you had a vasectomy? Yes _____ No _____ When? _____

Have you had a reverse vasectomy? Yes _____ No _____ When? _____

Have you experienced symptoms related to the vasectomy? Yes _____ No _____ Explain _____

_____

Do you have a history of prostate problems? Yes _____ No _____ Explain _____

_____

Date of last Prostate Exam _____

Most recent PSA results _____ Date _____

How often do you exercise? Never _____ Rarely _____ Sometimes _____ Regularly _____

Other information for us to know: _____