29995 Technology Drive Suite 201
Murrieta, Ca 92563
Telephone: (951) 461-3021
Fax: (951) 461-8898

Complete Male Medical History

Name: ________________________________ **DOB:** __________ **Date:** _____________

My Primary Health Concerns:

____

____

____

My Current Medical Problems:

____

____

____

Current Medications—Prescription & Non-Prescription (name/dose/reason/for taking)**:**

____

____

____

Allergies:

____

____

____

Current Supplements (name and dose):

____

____

____

Habits:

☐ Coffee _____ cups per day ☐ Tea _____ cups per day ☐ Soda ____ per day

Alcohol: ☐ Never ☐ Rarely ☐ Weekly ☐ Daily ☐ Gotten drunk in the past month? ☐ Yes ☐ No

☐ Beer ☐ Wine ☐ Liquor—number of drinks: ____ Felt the need to stop drinking? ☐ Yes ☐ No

☐ Energy drinks ______ per day ☐Exercise _____ times a week.

☐ Smoke cigarettes or cigars ______ per day ☐ Number of Years _____ ☐ Year Quit Smoking: _____

☐ Recreational Drugs: _________________________

Nutrition

List any diets you have been on during the past 12 months, along with the reason(s) for following it, the benefits or problems you experienced with it, and the reason(s) for stopping any diet:

____

____

____

____

____

____

____

Exercises

____

____

____

____

____

____

____

Current Sources of Stress

____

____

____

____

____

____

____

Miscellaneous

____

____

____

____

____

____

____

Hospital Admissions/Surgeries:

Year	Illness/Operation	Year	Illness/Operation

Screening Tests:

Screen	Date	Results?	Screen	Date	Results?
Cholesterol/Lipids			Dental Exam		
Blood Sugar			Eye Exam		
PSA (Prostate Text)			Skin Exam		
Prostate Exam			Other:		
Bone Density					
Colonoscopy					

Immunizations:

Immunization	Date	Immunization	Date	Immunization	Date
Tetanus/Td		Pneumonia		Varicella	
Influenza (FLU)		Hepatitis			

Family History:

Check boxes if a blood relative has suffered any of the following—indicate which relative(s), and give details below:

1. ☐ Anemia	2. ☐ Alcoholism	3. ☐ Alzheimer's	4. ☐ Arthritis
5. ☐ Asthma	6. ☐ Bleeds Easily	7. ☐ Cancer (type) ________________	8. ☐ Diabetes
9. ☐ Epilepsy	10. ☐ Glaucoma	11. ☐ Hay Fever	12. ☐ Heart Disease
13. ☐ Hepatitis	14. ☐ Hypertension	15. ☐ Lipid Disorder	16. ☐ Mental Illness
17. ☐ Osteoporosis	18. ☐ Stroke	19. ☐ Thyroid Diagnosis	20. ☐ Other:

Has your mother had a hip fracture after age 50? ☐ Yes ☐ No

Family History Details (indicate the number above, which relative(s) and explain):

____

____

____

Males (complete the following two sections):

Current Symptoms	**None**	**Mild**	**Moderate**	**Severe**	**Extreme**
Decline in your feeling of general well-being					
Joint pain and muscular ache					
Excessive sweating					
Sleep problems					
Increased need for sleep, often feeling tired					
Irritability					
Nervousness					
Anxiety					
Physical exhaustion/lack vitality					
Decrease in muscular strength					
Depressive mood					
Feeling that you have passed your peak					
Feeling burnt out, having hit rock bottom					
Decrease in beard growth					
Decrease in ability/frequency to perform sexually					
Decrease in the number of morning erections					
Decrease in sexual desire/libido					

Over the past month how often have you:	**Not At All**	**< 1 time in 5**	**< Half the time**	**Half the Time**	**> Half the Time**	**Almost Always**
Had sensation of not emptying bladder completely after urinating?						
Had to urinate again less than 2 hours after urinating?						
Stopped and started urinating several times?						
Found it difficult to postpone urination?						
Had a weak urinary stream?						
Had to push or strain to begin urinating?						
Typically, up to urinate from to getting up?						

Additional information you would like to share, or to elaborate on previous questions:

Medical History

Enter **'X'** and indicate age or dates for all questions which have ever applied to you.
'C' for current ongoing problems, providing dates and details

	Decreased Hearing		Abdominal Pain—Chronic
	Ringing in Ear		Gallbladder Trouble
	Ear Infections—Frequent		Jaundice/Hepatitis
	Dizzy Spells		Have Bowel Movement Every _____ day(s)
	Fainting Spells		Frequent: ☐ Constipation ☐ Diarrhea
	Failing Vision		Diverticulosis
	Eye Pain		Crohn's/Colitis
	Double or Blurred Vision		Bloody or Tarry Stools
	Nose Bleeds—Recurrent		Hemorrhoids
	Sinus Trouble		Hernia; type—
	Sore Throats—Frequent		Urination—Overactive Bladder
	Hoarseness—Prolonged		Overnight > than twice
	Dental Problems:		More than 8 times/24 hours
	Floss teeth _____ times per week		Urgency to Urinate
	Hay Fever/Allergies		Decrease in Urinary Force/Flow
	Pneumonia/Pleurisy		Painful Urination
	Bronchitis/Chronic Cough		Urine Leakage with: Exercise/Straining/Cough
	Shortness of Breath: ☐ Exertional ☐ Laying Flat		Blood in Urine
	Asthma/Wheezing		Kidney Stones
	Chest Pain		Urine Infections—Frequent
	Hight Blood Pressure		Sexually transmitted diseases:
	Heart Murmur		Recent Weight—☐ Gain ☐ Loss: lbs.
	Rapid Heart Beat		Desired Weight: lbs.
	Swollen Ankles		Anemia
	Irregular Pulse		Bruise Easily
	Palpitations		Blood Transfusions
	Leg Pain—when walking		Cancer: Type(s)—
	Varicose Veins/ Phlebitis		Chronic Fatigue
	Cold Numb Feet		Diabetes
	Loss of Appetite—Recent		Seizures
	Difficulty Swallowing		Stroke

	Heartburn		Tremor/Hands Shaking
	Peptic Ulcer		Numbness/Tingling Sensations
	Persistent Nausea/Vomiting		Headaches—Frequent
	Bone Fracture/Joint Injury		Arthritis: type/location:
	Fractures after Age 50? ☐ Yes ☐ No		Back Pain—Recurrent
	Foot Pain		☐ Acupuncture ☐ Tattoos
	Osteoporosis		Abuse: ☐ Physical ☐ Sexual ☐ Other
	Gout		Hair Loss: ☐ Progressive ☐ Recent
	Rashes		Do you have a lack of energy?
	Hives		Do you have less strength/endurance?
	Psoriasis		Have you lost height? ______inches
	Eczema		Decreased “enjoyment of life?”
	Sleeping Difficulty		Are you sad and/or grumpy?
	Concentration		Recent deterioration in ability to play sports?
	Depression		Are you falling asleep after dinner?
	Nervousness		Recent deterioration in work performance?
	Agitation		Do you have a decrease in libido?
	Memory loss		Satisfied with orgasm frequency? ☐ Yes ☐ No
	Moodiness		Are you sexually active? Past Current
	Suicidal thoughts		Opposite Sex ☐ ☐
	Phobias		Same Sex ☐ ☐
	Mental Illness		Single Partner ☐ ☐
	Feelings of worthlessness		Multiple Partners ☐ ☐
	Rheumatic Fever		Number of Sex Partners in Past Year: ________
	Scarlet Fever		Mumps
	Chicken Pox		German Measles
	Polio		Tuberculosis
	Mumps		Herpes
	German Measles		Aids/HIV
	Tuberculosis		Thyroid Disease

Patient Signature: ________________________________ **Date: ______________**