Winters Wellness Center- Michael A. Winters DC

Male Health History Questionnaire

GENERAL INFORMATION

Name ____ Today's Date ____________________

Address ______________________________________City _______________ State _____ Zip ____________

Home Phone ___________________________________ Work Phone __________________________________

Cell Phone ____________________________________ E-mail address ______________________________

Best time/place to contact you _______________________ May we e-mail you office newsletters? Yes __ No __

SS# ____ Marital Status: Married __ Single __ Widowed __ Divorced __

Age _____ Date of Birth ______________ Height ________ Weight ________ Occupation ____________________

Spouse/guardian name _______________________________ Spouse's date of birth ________________________

Employer's name & address ____

Who may we thank for referring you? ____

COMPLAINTS/CONCERNS

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

DAILY ACTIVITIES

Please list any daily activities which have been affected by the above conditions (examples: standing, sitting, bending, sports, anything at all)

____

____

____

SURGERY & Accident History

Have you had any surgery? (Please include all surgery)

1. Type: ____________________________________ When? ______________ Doctor ____________________
2. Type: ____________________________________ When? ______________ Doctor ____________________
3. Type: ____________________________________ When? ______________ Doctor ____________________
4. Type: ____________________________________ When? ______________ Doctor ____________________

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Have you had any accidents and/or injuries: auto, work-related or other? (Especially those related to your present problems).

1. Type: ______________________________ When? ____________ Hospitalized? Yes __ No __
2. Type: ______________________________ When? ____________ Hospitalized? Yes __ No __
3. Type: ______________________________ When? ____________ Hospitalized? Yes __ No __

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 & 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:____

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SLEEP/REST

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

Do you have trouble falling asleep? Yes ____ No _____

Do you feel rested upon awakening? Yes ____ No _____

Do you have problems with insomnia? Yes ____ No _____

Do you snore? Yes ____ No _____

Do you use sleeping aids? 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 ounces wine, 12 oz. beer, 1.5 ounces 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 _______

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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 cravings				
Salt cravings				
Anger/Aggression				
Irritability				
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: ____

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