

Integrative Medicine Center

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NAME: _____

Male Personal History Form

Major Symptoms

What brings you in today (major complaint)? _____

How frequent and severe are your symptoms? _____

How long have you had these symptoms? _____

What makes your symptoms worse? _____

What makes your symptoms better? _____

How do your symptoms interfere with your daily life, family life, and career? _____

Treatment received so far:

What tests, medicines and consultations have been done so far? _____

Has this treatment helped? _____

Were there any complications with any previous treatments? _____

Previous Medical History—Please check any conditions that apply to you

- | | | |
|---|--|---|
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Poor Sex Drive | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Enlarged Prostate | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Childhood onset | <input type="checkbox"/> Adult onset |
| Please give age of diagnosis. _____ | | |
| <input type="checkbox"/> Arthritis | Where are you affected? _____ | |
| <input type="checkbox"/> Coronary artery disease or heart disease | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Other medical conditions: _____ | | |

Surgical History—Please check any prior surgeries that apply to you

- | | | | |
|---|---|---|-----------------------|
| <input type="checkbox"/> Adenoid removal | <input type="checkbox"/> Sinus surgery | <input type="checkbox"/> Tubes in ears | How many times? _____ |
| <input type="checkbox"/> Gall Bladder removal | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Appendix removal | |
| <input type="checkbox"/> Heart Studies | <input type="checkbox"/> Joint replacement Which joint? _____ | | |
| <input type="checkbox"/> Blood Type: _____ | <input type="checkbox"/> Other: _____ | | |

Medications/Supplements

Please list all prescriptions, over the counter medications, and vitamins and dosages you are currently using. _____

List all known allergies to food, drugs or environment: _____

Social History:

Who lives at home besides you? _____

Are they healthy? _____ Number of children? _____

Do you or anyone at home smoke? Yes No If yes, how many per day? _____

Do you have any animals? Yes No

If yes, what kind and how many do you have? _____

What is your job? _____

Has this or any other job put you around strong chemicals or smoke? Yes No

If yes, please explain: _____

Family Medical History

Please check the appropriate box for you and your family member if any of the following apply.

	Self	Mother	Father	Grandparents	Siblings	Children
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list what type of cancer and what age it was found. _____

Please list other health concerns you may have: _____

Review of Systems: check all that apply

Head, Emotions, and Mind

Headaches Where does it bother you? _____
 Migraine Headaches How frequent? _____

-
- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Become irritable or angry easily | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Reduction of memory | <input type="checkbox"/> Tremor |
| <input type="checkbox"/> Numbness/tingling | | <input type="checkbox"/> Cannot think clearly—foggy thinking | <input type="checkbox"/> Restless Legs |
| <input type="checkbox"/> Loss of train of thought | | <input type="checkbox"/> Reduction in concentration | |
-

Present performance inferior to prior performance in level functioning (please explain): _____

Hormone Axis

- Fatigue
- Decreased libido
- Loss of mental sharpness
- Poor short term memory
- Decreased muscle mass
- Loss of confidence
- Poor decision making

Digestive Tract: check all that apply

- Constipation
- Bad Breath
- Poor sense of taste
- Diarrhea
- Heartburn/Indigestion
- Blood in stool
- Belching
- Hemorrhoids
- Nausea
- Bloating with meals
- Sugar cravings

Energy-Activity

- Get tired easily
- Feel cold at temperatures that other people are comfortable
- Muscular weakness or muscles tire easily
- Wake up tired
- Sleep excessively
- Weight gain
- Muscle cramps

Skin: check all that apply

- Cold hands
- Psoriasis
- Facial puffiness in the morning
- Cold feet
- Acne
- Dry skin
- Loss of scalp hair
- Hives
- rashes/eczema

Cardiovascular: check all that apply

- High blood pressure
- Chest pain
- Varicose veins
- Rapid heartbeat
- Snore while sleeping
- Mitral Valve Prolapse
- Skipped heartbeat
- Fluid collection in feet

Urinary tract/bladder: check all that apply

- Kidney/bladder infections Number of times _____
- Frequent urination
- Awake at night to urinate
- Burning upon urination
- Blood in urine
- Prostate Infection

Nose: check all that apply

- Stuffy nose
 - Hay fever
 - Runny nose
 - Sinus infections Number per year _____
- Have x-rays been done of the sinuses? No Yes If so, where? _____

Lungs: check all that apply

- Wheezing
- Difficulty breathing
- Asthma
- Bronchitis
- Ever had a chest x-ray
- Chest congestion

Mouth, Throat and Ears: check all that apply

- Sore throats How many per year? _____
 - Ear infections
 - Bad breath
 - Canker sores
 - Ringing in ears
-

Eyes: check all that apply

- Watering or itching Cataracts Dry eyes Macular degeneration
 Visual Changes

Specific Health Questions: Please answer/explain as completely as possible

Do you crave or over consume sugar (sweets), chocolate, caffeine, or alcohol? _____

If you skip caffeine, do you get caffeine withdrawal headaches? Yes No

Do you feel sleepy, tired, stuffy nose, indigestion, or abdominal pain or other kinds of symptoms after certain meals?

In early childhood, did you experience: (check all that apply)

- Frequent colds Frequent sore throats Frequent ear infections
 Eczema Frequent sinus infections Asthma
 Adverse reactions to immunizations Exposed to tobacco smoke, chemicals
 Multiple stays in the hospital ____ If yes, please give reason/s for hospital stays:

In your teenage years to early adulthood, did you experience any of the above or:

- Hay fever Bladder/kidney infections Depression

Do any of the above symptoms continue currently? (please list and explain)

