

ADULT MEN'S MEDICAL QUESTIONNAIRE

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. These questions will help to identify underlying causes of illness and will also assist in formulating a treatment plan.

Please write clearly in black ink.

PERSONAL INFORMATION

First Name: _____ Last Name: _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Date of Birth: ____/____/____
mo day year Place of Birth: _____

Provincial Health Card Number: _____

Occupation: _____ Referred by: _____

Marital Status: _____ Number of Children: _____

Height: ____ ft ____ in Weight: _____ lbs

Name of your Family Doctor: _____

Who to contact in case of emergency: _____

Phone Number: _____

Relationship to emergency contact: _____

CURRENT MEDICAL ISSUES

Please rank current and ongoing problems by priority and fill in the other boxes as completely as possible:

Describe Problem	Mild/Moderate/ Severe	Treatment Approach	Success
Example: Post Nasal Drip	Moderate	Elimination Diet	Moderate

PAST MEDICAL AND SURGICAL HISTORY

Do you have or have you ever had any of the following? Please include approximate date.

Illness	<input checked="" type="checkbox"/>	Date	Comments
Recurrent Sinusitis	<input type="checkbox"/>		
Chronic Bronchitis	<input type="checkbox"/>		
Asthma	<input type="checkbox"/>		
Emphysema	<input type="checkbox"/>		
Tuberculosis	<input type="checkbox"/>		
Angina	<input type="checkbox"/>		
Heart Attack	<input type="checkbox"/>		
Arrhythmia	<input type="checkbox"/>		
High Blood Pressure	<input type="checkbox"/>		
Stroke	<input type="checkbox"/>		
Heart Failure	<input type="checkbox"/>		
Rheumatic Fever	<input type="checkbox"/>		
High Cholesterol	<input type="checkbox"/>		
Hepatitis	<input type="checkbox"/>		
Gallstones	<input type="checkbox"/>		
Irritable Bowel Syndrome	<input type="checkbox"/>		
Crohn's or Colitis	<input type="checkbox"/>		
Chronic Kidney Disease	<input type="checkbox"/>		
Diabetes	<input type="checkbox"/>		
Thyroid Disease	<input type="checkbox"/>		
Epilepsy	<input type="checkbox"/>		
Anemia	<input type="checkbox"/>		
DVT (Blood clots in legs)	<input type="checkbox"/>		

Illness cont'd	<input checked="" type="checkbox"/>	Date	Comments
Chronic Fatigue Syndrome	<input type="checkbox"/>		
Cancer (Specify type)	<input type="checkbox"/>		
Other:	<input type="checkbox"/>		
Injuries	<input checked="" type="checkbox"/>	Date	Comments
Head Injury/Concussion	<input type="checkbox"/>		
Back/Neck Injury	<input type="checkbox"/>		
Broken bones (describe)	<input type="checkbox"/>		
Other:	<input type="checkbox"/>		
Diagnostic Studies	<input checked="" type="checkbox"/>	Date	Comments
CT Scan (specify number and body part)	<input type="checkbox"/>		
Barium Studies	<input type="checkbox"/>		
Bone Density Scan	<input type="checkbox"/>		
Mammogram	<input type="checkbox"/>		
Colonoscopy	<input type="checkbox"/>		
MRI (specify body part)	<input type="checkbox"/>		
Surgical History	<input checked="" type="checkbox"/>	Date	Comments
Appendectomy	<input type="checkbox"/>		
Tonsillectomy	<input type="checkbox"/>		
Gall Bladder/Cholecystectomy	<input type="checkbox"/>		
Hysterectomy	<input type="checkbox"/>		
Hernia	<input type="checkbox"/>		
Prostate	<input type="checkbox"/>		
Other (describe)	<input type="checkbox"/>		
Other (describe)	<input type="checkbox"/>		

MEDICATIONS AND SUPPLEMENTS

What medications are you taking now? Include over-the-counter medications.

Medication Name	Dosage/Frequency	Date Started

Are you allergic to any medications? Yes No

If yes, please list medication and the nature of the reaction you had to it:

List all vitamins, minerals, and other nutritional supplements you are taking now.

Vitamin/Mineral/Supplement Name	Dosage/Frequency	Date Started

CURRENT MEDICAL SYMPTOMS

Please indicate if these symptoms occur presently **or** have occurred in the past 6 months.

General	Mild	Mod- erate	Severe	Musculoskeletal	Mild	Mod- erate	Severe
Cold hands & feet				Joint pain			
Cold intolerance				Joint stiffness			
Heat intolerance				Muscle pain			
Difficulty falling asleep				Muscle spasms			
Early waking				Muscle weakness			
Night waking				Tension headache			
Daytime sleepiness				TMJ problems			
Flushing							
Fatigue				Mood/Nerves			
				Anxiety			
Head, Eyes & Ears				Panic attacks			
Conjunctivitis				Depression			
Ear fullness				Suicidal thoughts			
Ear ringing/buzzing				Irritability			
Headache				Fainting			
Hearing problems				Dizziness (spinning)			
Migraine				Light-headedness			
				Difficulty with memory			

Mood/Nerves cont'd	Mild	Mod- erate	Severe
Difficulty concentrating			
Numbness			
Eating			
Anorexia			
Bulemia			
Binge eating			
Can't gain weight			
Can't lose weight			
Salt craving			
Carbohydrate craving			
Skin Problems			
Acne			
Dark circles under eyes			
Easy bruising			
Eczema			
Psoriasis			
Herpes – genital			
Hives			
Shingles			
Skin cancer			
Vitiligo			
Chronic itching			

Digestion	Mild	Mod- erate	Severe
Bleeding gums			
Bloating			
Blood in stools			
Burping			
Canker sores			
Cold sores			
Constipation			
Cracking lips			
Diarrhea			
Dry mouth			
Fissures			
Heartburn			
Hemorrhoids			
Intolerance to:			
Lactose			
Gluten			
Corn			
Eggs			
Fatty foods			
Yeast			
Liver disease/jaundice			
Nausea			
Persistent Lymph Nodes			
Neck/Groin/Armpits			

FAMILY HISTORY INFORMATION

Are there any significant illnesses in your family history? If so, please indicate the condition of each family relation.

Relation	Illnesses
Father	
Mother	
Sibling	
Sibling	
Maternal grandfather	
Maternal grandmother	
Paternal grandfather	
Paternal grandmother	

DIETARY INFORMATION

Please carefully list an average day's food consumption. Try to be as detailed as possible, and include the number of glasses of water, juice, coffee, or other beverages in the space provided. Exact portion sizes need not be listed.

Breakfast (_____ am) _____

Lunch (_____ am / pm) _____

Dinner (_____ pm) _____

Snacks: Mid Morning: _____

Mid Afternoon: _____

After Dinner: _____

Daily Beverages: _____

Do you have any food cravings? Yes No

If yes, do you crave sweets? _____ Breads/pastas? _____ Salty foods? _____

Are you on a special diet? Yes No

If yes, please specify: _____

Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc.? Yes No

If yes, please list the particular food or supplement associated with your symptoms.

Please fill in the chart below:

Bowel Movements			
Frequency	<input checked="" type="checkbox"/>	Consistency	<input checked="" type="checkbox"/>
More than 3 times a day		Soft and well formed	
2 to 3 times a day		Small and hard	
1 time a day		Loose but not watery	
3 to 5 times a week		Alternating between hard	
2 or fewer times a week		& loose/watery	
		Pencil thin	
Intestinal Gas			
Daily		Present with pain	
Occasionally		Foul smelling	
Excessive		Little odor	

How often do you now drink alcohol?

- _____ Do not drink alcohol
- _____ No longer drinking alcohol
- _____ 0-5 drinks per month
- _____ Average 1-6 drinks per week
- _____ Average 7-10 drinks per week
- _____ Average >10 drinks per week

Have you ever had a problem with alcohol? Yes No

If yes, please indicate time period (month/year): from _____ to _____

Have you ever used recreational drugs? Yes No

Which drugs presently _____

Which drugs in the past _____

Have you ever used tobacco? Yes No

If yes, number of years as a nicotine user _____ Amount per day _____ Year quit _____

LIFESTYLE INFORMATION

With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.) Example: Wendy, age 7, sister

Are you currently, or have you ever been, married? Yes No

If so, when were you married? _____ Spouse's occupation _____

When were you separated? _____ Never _____

When were you divorced? _____ Never _____

Have you or your family recently experienced any major life changes? Yes No

If yes, please comment:

Have you experienced any major losses in life? Yes No

If so, please comment:

Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. .

Have you been involved in abusive relationships in your life?

Yes No If yes, as a child? _____ As an adult? _____ Presently? _____

How well have things been going for you?

	Very Well	Fair	Poorly	Very Poorly	N/A
At school					
In your job					
In your social life					
With close friends					
With sex					
With your attitude					
With your boyfriend/girlfriend					
With your children					
With your parents					
With your spouse					

What are your hobbies and leisure activities:

Do you exercise regularly? Yes No

If so, how many times a week? When you exercise, how long is each session?

_____ 1x	_____ ≤ 15 min
_____ 2x	_____ 16-30 min
_____ 3x	_____ 31-45 min
_____ 4x or more	_____ ≥ 45 min

What type of exercise is it?

Jogging		Walking		Hiking	
Cycling		Snow sports		Water sports	
Strength training		Aerobics		Martial Arts	
Other (comment)					

MEN'S HEALTH INFORMATION

Do you have or have you ever had:

Discharge from your penis _____ Genital pain _____ Genital infection _____
 Lumps in testicles _____ Low sex drive _____ Blood in sperm _____

Problems with erections:

Difficulty becoming erect _____ Difficulty maintaining erections _____
 Erections not as firm _____

Urinary symptoms:

Hesitancy _____ Urgency _____ Burning _____ Leaking _____ Frequency _____