

**Pinnacle Health Solutions (360)705-0900**  
**Male Health History Questionnaire**

**GENERAL INFORMATION**

Today's Date \_\_\_\_\_  
 Name: Mr./Mrs./Ms. \_\_\_\_\_ Address \_\_\_\_\_  
 Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_  
 Work ( ) \_\_\_\_\_  Cell ( ) \_\_\_\_\_ Best place to reach you:  Home  Work  Cell  
 If necessary, may we leave a message for you at any of the above numbers? Yes / No  
**Email:** \_\_\_\_\_ **SSN** \_\_\_\_\_  
 Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Duration of Employment: \_\_\_\_\_ Age: \_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
 Sex: M F Martial Status: S M W Name (First/Last) of Spouse or Partner: \_\_\_\_\_  
 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 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.			

**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: \_\_\_\_\_

## 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 2<sup>nd</sup> 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 \_\_\_\_\_

## 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 \_\_\_\_\_

