Medical History Form (Male)

Name: ____ Age ___________ DOB: _________________

PLEASE COMPLETE THE FOLLOWING (STRICTLY CONFIDENTIAL):

What is the primary reason for your visit? ____

How would you rate your general health? Excellent Good Fair Poor

Do you have any present health concerns or symptoms: ______________________________________

Food Allergies: _____ Yes ____No If Yes, Please list ____
Drug Allergies: _____ Yes ____No If Yes, Please list ____

List ALL medication and doses (including over the counter medications)

___________________________________ ____
___________________________________ ____
___________________________________ ____

Do you currently smoke? ____Yes ____No If yes, how much and how long? _______________________
Frequency of alcoholic beverages (approx # per week) ____
Any other recreational drugs? Yes _____ No _______

Please indicate if you have any of the following medical problems and when:

Prostate Problems	Yes	No	When?	Cancer	Yes	No	When?
High Blood Pressue	Yes	No	When?	Type of Cancer			
High Cholesterol	Yes	No	When?	Prostate Problems	Yes	No	When?
Thyroid Problems	Yes	No	When?	Alcohol Addiction	Yes	No	When?
Diabetes	Yes	No	When?	Drug Addiction	Yes	No	When?
Clotting Disorder	Yes	No	When?	Eating Disorder	Yes	No	When?
Heart Attack	Yes	No	When?	Other ______________________			

Prior Surgeries/Hospitalization:

_______________________When?___________ _______________________When?________________
_______________________When?___________ _______________________When?________________

Family History:

Heart Disease	Yes	No	Who?____________	Stroke	Yes	No	Who?_____________
High Blood Pressure	Yes	No	Who?____________	Blood Clots	Yes	No	Who?_____________
High Cholesterol	Yes	No	Who?____________	Cancer	Yes	No	Who?_____________
Diabetes	Yes	No	Who?____________	Other ______________			

Have you had your PSA checked within the last year? ___Yes ___No Results: ___Normal ___Abnormal

Weight History:

Has your weight changed recently? _____Yes _____No Gained ____ Loss _____ # of lbs ___________

Exercise History:

Do you exercise regularly? _______Yes ______No How often? _____________ How long? ________________