Spine Arts Center

Male Health History Questionnaire
(To be completed by patient)

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Weight: _____ Height: _____

Chief Complaint(s):

_____
_____
_____

Prescription Drug Usage – Please check if you use any of the following & then list exact names of any medications you are currently using:

☐ Antacids, Zantac, Pepcid, Rolaids, etc.
☐ Chemotherapy

☐ Laxatives
☐ Ulcer Medications
☐ Antibiotic/Antifungal

☐ Anti-Diabetic/Insulin

☐ Oral Contraceptives
Medications

☐ Relaxants/Sleep pills
☐ Thyroid
☐ Radiation
☐ Antidepressants

☐ Aspirin/Acetaminophen

☐ Cortisone/Anti-Inflammatory
☐ Heart Medications
☐ High Blood Pressure Medicine
☐ Statins/Cholesterol Lowering

☐ Hormones – If so, what? _____ When? _____ Dosage? _____

Please list names of any medications you are currently taking:

_____
_____
_____
_____
_____

Are you allergic to any drugs that you know of? (if so please list names):

_____
_____

Supplement/Vitamin Usage – Please list any supplements/vitamins you are currently taking:

_____
_____
_____
_____
_____

Surgeries, Accidents, Traumas – Please list any surgeries, accidents, or trauma's you have had. Please be sure to include dates as well.

_____
_____
_____
_____
_____

Lifestyle

Dietary Habits: Describe the foods you normally eat:
BREAKFAST: _____
_____
LUNCH: _____
_____
DINNER: _____
_____
SNACKS: _____
_____

Do you consume the following?			**If so, how much?**
1. Soda or carbonated beverages?	YES	NO	_____
2. White flour products?	YES	NO	_____
3. Fried foods?	YES	NO	_____
4. Coffee?	YES	NO	_____
5. Fast foods regularly?	YES	NO	_____
6. Sweets and /or refined carbohydrates?	YES	NO	_____
7. Alcoholic beverages?	YES	NO	_____
8. Any tobacco products?	YES	NO	_____

Are you a vegetarian? YES NO

Are you currently involved in an exercise program? YES NO How often? _____

How would you rate your stress level? (1=Low, 10=Extreme) 1 2 3 4 5 6 7 8 9 10
How do you rate your stress handling? (1=Poor, 10=Excellent) 1 2 3 4 5 6 7 8 9 10

Male Anatomy

Have you had a vasectomy? YES NO When? _____

Experienced any symptoms related to the vasectomy? YES NO

If so, please explain: _____
_____

Reverse vasectomy? YES NO When? _____

Do you have any history of prostate problems? YES NO
If so, please explain: _____
_____

When was your last prostate exam? _____

What were your most recent PSA results? _____ Date: _____

Does your bladder always feel full? YES NO SOMETIMES

Do you experience inconsistent pressure or pain during urination? YES NO SOMETIMES

Does ejaculation cause pain? YES NO SOMETIMES

Do you experience low sex drive? YES NO SOMETIMES

Do you have premature ejaculation? YES NO SOMETIMES

Sleep

How well do you sleep?
☐ Well ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Insomnia

What is the average number of hours you most often sleep each night? _____
Do you wake up with night sweats? YES NO

When you wake in the morning do you still feel tired? YES NO
If yes, how often? _____

Do you keep your room completely dark at night? YES NO

_____

Patient/Guardian (Please Print)

_____ Date: _____

Patient/Guardian (Signature)

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