

MALE Medical History Questionnaire

Have you had any of the following problems in the last year?

GENERAL

- Excessive fatigue
- Unexplained loss of weight

- Chills or fever

NEUROLOGICAL

- Trouble sleeping
- Numbness or tingling
- Shooting pains

PSYCHIATRIC

- Worries or fears
- Depressed feelings
- Psychiatric care or treatment

EARS, NOSE AND THROAT

- Hearing loss
- Nose bleeds
- Blocked sinuses

EYES

- Changes in you sight
- Changes in your vision
- Glaucoma

RESPIRATORY SYSTEM

- Wheezing or asthma
- Shortness of breath
- Chronic persistent cough

CARDIOVASCULAR SYSTEM

- Chest pain or tightness
- Rapid or irregular heart beats

- High blood pressure
- Foot or ankle swelling

DIGESTIVE TRACT

- Nausea
- Heartburn
- Gas or bloating
- Constipation
- Diarrhea

BONES AND JOINTS

- Joint pain
- Back pain
- Muscle weakness
- Broken bones

MALE REPRODUCTIVE

- Difficulties with erection
(Request **IIEF** questionnaire)
- Diminished sexual drive
(Request **AMS** questionnaire)
- Ejaculation problems (
(Request **PEP** questionnaire)

UROLOGICAL

- Blood in the urine

- Problem urinating
(Request **ISC** questionnaire)
- Pelvic pain/voiding problems
(Request **CPSI** questionnaire)
- Involuntary urine leakage
(Request **ISC** questionnaire)
- Urinary infection
 - of kidney
 - of bladder
- Urinary stones
 - in kidney
 - in ureter
 - in bladder

SKIN

- Sensitive skin
- Skin rash
- Non healing sores

ENDOCRINE SYSTEM

- Excessive thirst
- Thyroid problems
- Steroid use
- Diabetes

LYMPH & HEMATOLOGICAL

- Anemia
- Easy bruising or bleeding
- Enlarged lymph glands
- Blood transfusion

PATIENT NAME

AGE