Medical History Form (Men)

First Name: _____ Last Name: _____

Do you currently have any of these symptoms? ✓ If you do

☐ Abdominal Pain	☐ Depression	☐ Headaches	☐ Sexual Dysfunction
☐ Anxiety	☐ Diarrhea	☐ Irregular Heart Beat	☐ Shortness of Breath
☐ Back Pain	☐ Dizziness	☐ Joint Pain	☐ Sore Throat
☐ Blood in Urine	☐ Earache	☐ Leg Swelling	☐ Swollen Glands
☐ Chest Pain	☐ Easy Bruising	☐ Mole Changes	☐ Urinary Frequency
☐ Chills	☐ Excessive Thirst	☐ Nasal Congestion	☐ Vomiting
☐ Constipation	☐ Fatigue	☐ Numbness	☐ Weight Loss
☐ Cough	☐ Fever	☐ Rash	☐ Wheezing

Please list all previous medical problems: ☐ None

_____

_____

_____

Please list any surgeries or medical procedures that you have had (include dates): ☐ None

_____

_____

_____

Do you have any allergies to medication? ☐ No ☐ Yes (If yes, please list the specific medication(s) and the type of reaction you had): _____

_____

Please list diseases which run in your family (include relationship, e.g. Mother, Father etc.):

_____

How much tobacco do you smoke? ☐ None ☐ under 1 pack/day ☐ 1 pack/day ☐ Over 1 pack/day
How much alcohol do you drink? ☐ None ☐ Moderate (2 drinks/day or less) ☐ Heavy (over 2 drinks/day)

Do you have a substance abuse history? ☐ Yes ☐ No

If yes, please explain: _____

Please list your current medications (include dose and frequency): ☐ None

_____

_____

_____