atient	name:	
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## MALE HEALTH HISTORY QUESTIONNAIRE

Name		la in	Age:	I oday's date:	
Pirth Data:	Weight:		Occupation:		
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1. What is the reas	on for time viete.				
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<ol><li>List medications</li></ol>	you are currently taki	ing:			intotal Lay esaid
	<u> </u>		i say semalika	g stateong to yagte	of the second way of the
3. Any known drug	allergies?		i say sumettu		
4. Do you or have	you used hormone rep	placement therapy?	Yes No		
4. Do you or have		placement therapy?	Yes No		
4. Do you or have	you used hormone rep	placement therapy?When?	Yes No	Dosage?	hard to should
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Patient name:	

<u>LIFESTYLE INDICATORS</u> <= less than >= greater than or stopped recently
1. Do you use any of the following? (circle responses)
Alcohol None <2 drinks/day >2 drinks/day or stopped recently(when?)
Coffee None <2 cups/day >2 cups/day or stopped recently(when?)
Soda None <2 cans/day >2 cans/day or stopped recently(when?)
Sweets/refined carbs <twice day="">twice/day or stopped recently(when?)</twice>
Do you smoke cigarettes/cigars or use nicotine gum or other stimulants? (circle) Y N Amount
3. How would you rate your stress level? (1=Low, 10=Extreme) 1 2 3 4 5 6 7 8 9 10
4. How would you rate your stress handling? (1=Poor, 10=Excellent) 1 2 3 4 5 6 7 8 9 10
5. How often do you exercise? never rarely sometimes regularly competitively
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:
Explain:
4. Do you have a history of prostate problems? Yes No
Explain:
Source disconnection accounce heat show over the university of
Secretary Control Cont
Date of last Prostate Exam
Date of last Prostate Exam Date Date
SLEEP HABITS
1. How do you sleep? Well Trouble falling asleep Trouble staying asleep Insomnia
How long has this been happening?
2. How many hours do you sleep a night on average?
Do night sweats wake you up? Yes No How often?
4. Do you wake up tired? Yes No How long has this been happening?
5. Is your room completely dark when you sleep at night? (no night light, street lamp, TV, etc.) Yes No
6. Do you get at least 30 minutes of outside daylight time, several days each week? Yes No

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tient name:		

SIGNS & SYMPTOMS	MILD	MODERATE	SEVERE	ADDITIONAL COMMENTS
Low mood / Depression				
Irritability				
Anxiety				,
Anger / Aggression	-			
Discouragement / Pessimism				
Decreased interest in activities / relationships				
Decreased initiative / motivation / drive			= 29,53	
Decreased productivity at work			1.4	
Concentration problems				
Memory problems				
Foggy thinking	h and			
Increased fatigue		- 1		
Decrease in strength / stamina	17.510474			
Decrease in athletic performance				
Decreased lean muscle mass				
Muscle soreness / weakness				
Body / joint aches				
Weight loss				
Weight gain				
Increased fat on hips / breasts / thighs				
	-			
Low blood sugar / hypoglycemia	-	-		
Sweet cravings (carbs/chocolate)				
Caffeine/Stimulant cravings		+		
Salt cravings		-		
Constant hunger		_		
Elevated cholesterol				
Elevated blood pressure				
Digestive problems				
Head hair loss				
Need to shave less frequently				
Body hair loss				
Dry skin / thinning skin				
Decreased spontaneous morning erections				
Lowered Libido		70(0.0000000000000000000000000000000000		
Erectile Dysfunction (ED)				
Pain with ejaculation				ALL STATES
Frequent need to urinate				
Urination is delayed/strained/incomplete				
Pain with urination				
Blood in the urine				
Bone loss/osteoporosis				
Other				