

HEALTH QUESTIONNAIRE for MEN

Your Name:

Birth date:

Date:

To help us with your Health Maintenance Visit (HMV), please update the following for your doctor:

1. *Any special concerns today?*

2. *Lifestyle/Social History (please circle or fill in):*

- a. Tobacco use: no yes; type \ amount per day _____
- b. Caffeine: no yes; type \ amount per day _____
- c. Alcohol \ Drugs: no yes; type \ amount per day _____
- d. Diet: Meals per day _____
- e. Exercise: no yes; type \ amount per week _____.
- f. Are you single and sexually active? no yes NA
- g. Seat belt use: yes no Smoke alarm in home: yes no Guns in home: no yes
- h. Any health risks associated with your work? no yes; type _____.
- i. If married, how would you rate your marriage? _____ ; # of children _____

3. *Review of systems (please circle or fill in significant symptoms since last HMV):*

- a. General - fever, weight loss, weight gain, fatigue, loss of appetite.
- b. Skin - rash, new mole or change in mole.
- c. Eyes - blurred vision, double vision, redness. Last eye exam _____.
- d. ENT - hearing loss, sinus pain, difficult swallowing, hoarseness. Last dental visit _____.
- e. Allergy - sneezing, itching or watering eyes.
- f. Respiratory - cough, wheeze, sputum, tuberculosis exposure.
- g. Cardiovascular - chest pain, shortness of breath, palpitations, swelling in feet. Cholesterol _____
- h. GI - nausea, vomiting, diarrhea, constipation, blood in stool, abdominal pain.
- i. GU - pain with urination, frequent urination, blood in urine, problems with erection, sexually transmitted disease Family planning method - type: _____
- j. Endocrine - excess thirst, urination or appetite; heat or cold intolerance, fatigue, nervousness.
- k. Blood/Immune System - easy bruising or bleeding, anemia, recurrent infections
- l. Musculoskeletal – joint pain, swelling, loss of motion; which joints?
- m. Neurologic - headache, numbness, weakness, dizziness.
- n. Psych - stress, depression, sleep disturbance, trouble in your home.

4. *Immunizations* (dates): Tetanus _____ Flu _____ Pneumovax _____

5. *Do you have an advanced directive or living will?* yes no

6. *Current medications, including over the counter products (list name and dosage):*

7. *Medication Allergies / Side Effects:*

8. *Hospitalizations & Surgeries (Month/Year/Problem):*

9. *Illness or death in your immediate family (parents, siblings, children):*