CONFIDENTIAL MEDICAL/HEALTH PROFILE - MALE

Name_____ Date_____
Address_____ DOB_____
City/State/Zip_____ Age_____Sex: ___M___F
Phone: Work_____Res_____ Height_____Weight_____
Cell Phone_____ Email_____
Employer_____ Occupation_____
Referred by_____ **Blood Type** _____

Iris Color: __Lymphatic __Biliary __Hematogenic Film Roll No: _____Exposure Setting _____

How do you rate your overall general health? ____Excellent ____Good ____Fair ____Poor
Are you under a physician's care now?___Yes ___No For what:_____
Primary Care Physician_____

MEDICATIONS: (Use another sheet or write on back if more space is needed)

Name of Medication Dosage (strength) Frequency

_____
_____
_____
_____
_____
_____
_____

Do you take any street drugs? ___Yes ___No Please list:_____

Reason for visit: Please list your most important present health concerns in order of significance:

1_____ 5_____
2_____ 6_____
3_____ 7_____
4_____ 8_____

History of Surgery: (List type and approximate date and age)

_____
_____
_____
_____
_____

CLIENT _____

Please list any significant physical trauma (accident or injury, and at what age)

_____

_____

_____

_____

Please list any significant mental/emotional trauma (and at what age)

_____

_____

_____

_____

How would you describe your current emotional condition?

_____

_____

_____

Do you have energy swings/surges during the day? ___Yes ___No Please explain:_____

_____

Frequency of bowel movements: _____per day or _____per week ___loose ___normal ___hard

Any bowel issues?_____

Prostate gland problems/ ___Yes ___No If yes, describe_____

Urinary frequency_____Dffiicult urination_____

Other problems_____

Date of last PSA Tes_____Result, if known_____

Date of last prostate exam_____Findings_____

FAMILY HISTORY - CAUSE OF DEATH (Blood Relatives)

	Age, if alive	Age at Death	Cause of Death
MOTHER	_____	_____	_____
Maternal GM	_____	_____	_____
Maternal GF	_____	_____	_____
Longevity present in other familiy members	_____		
FATHER	_____	_____	_____
Paternal GM	_____	_____	_____
Paternal GF	_____	_____	_____
Longevity present in other family members	_____		

Other significant factors:_____

_____

_____

_____

PERSONAL HEALTH HISTORY

(Please check all that apply) **CLIENT** _____

SKIN
- ☐ Rashes
- ☐ Eczema, Hives
- ☐ Acne, Boils
- ☐ Itching
- ☐ Color change
- ☐ Lumps
- ☐ Warts
- ☐ Night Sweats

EYES
- ☐ Impaired Vision
- ☐ Glasses, Contacts
- ☐ Eye Pain
- ☐ Tearing, Dryness
- ☐ Double Vision
- ☐ Glaucoma
- ☐ Cataracts

EARS
- ☐ Imparied Hearing
- ☐ Ringing
- ☐ Earache
- ☐ Dizziness

NOSE & SINUSES
- ☐ Frequent Colds
- ☐ Nose Bleeds
- ☐ Stuffiness
- ☐ Hayfever
- ☐ Sinus Problems

MOUTH & THROAT
- ☐ Frequent Sore Throat
- ☐ Sore Tongue
- ☐ Gum problems (periodontal)
- ☐ Hoarseness
- ☐ Bad Breath

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Broken Bones
- ☐ Joint Pain, Stiffness
- ☐ Muscle Spasms, Cramps
- ☐ Weakness

RESPIRATORY
- ☐ Prolonged Cough
- ☐ Sputum
- ☐ Spitting up Blood
- ☐ Wheezing
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Pleurisy
- ☐ Emphysema
- ☐ Difficulty Breathing
- ☐ Pain on Breathing
- ☐ Shortness of Breath
  - ___at night
  - ___lying down
- ☐ Tuberculosis

CARDIOVASCULAR
- ☐ Angina, Chest Pain
- ☐ Angioplasty
- ☐ Arrhythmia
- ☐ Arteriosclerosis
- ☐ Artificial Heart Valves
- ☐ Atherosclerosis
- ☐ Blood Pressure - High
- ☐ Blood Pressure - Low
- ☐ Bypass Surgery
- ☐ Cardiac Pacemaker
- ☐ Congenital Heart Lesions
- ☐ Coronary Stent
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ High Cholesterol
- ☐ Mitral Valve Prolapse
- ☐ Palpitations, Fluttering
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Swelling in Ankles

BLOOD
- ☐ Anemia
- ☐ Easy bleeding/bruising
- ☐ Leukemia

URINARY
- ☐ Frequency at Night
  - ___times per night
- ☐ Increased Frequency
- ☐ Frequent Infections
- ☐ Inability to hold urine
- ☐ Kidney Stones
- ☐ Pain with urination

GASTROINTESTINAL
- ☐ Trouble swallowing
- ☐ Heartburn
- ☐ Change in thirst
- ☐ Change in appetite
- ☐ Nausea/vomiting
- ☐ Vomiting blood
- ☐ Blood in stool
- ☐ Bowel move ___ day/wk
- ☐ Belching, pass gas
- ☐ Jaundice
- ☐ Liver disease

MALE REPRODUCTIVE
- ☐ Hernias
- ☐ Testicular Masses
- ☐ Testicular Pain
- ☐ Sexual Difficulties
- ☐ Prostate Disease
- ☐ Venereal disease
- ☐ Discharge, Sores
- ☐ Impotence
- ☐ Dificulty urinating
- ☐ Recent onset of curvature of penis

CLIENT _____

PERIPHERAL VASCULAR
- ☐ Chill easily
- ☐ Circulatory Problems
- ☐ Cold Hands/Feet
- ☐ Deep leg pain
- ☐ Thrombophlebitis
- ☐ Varicose Veins

ENDOCRINE
(Adrenals, pancreas, parathyroid, pineal , pituitary, male/female sex glands, thymus, thyroid)
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Heat/Cold Intolerance
- ☐ Excessive Thirst
- ☐ Excessive Hunger
- ☐ Diabetes
- ☐ Gallstones
- ☐ Low Blood Sugar/ Hypoglycemic

NEUROLOGIC
- ☐ Fainting
- ☐ Seizures
- ☐ Headache
- ☐ Head Injury
- ☐ Paralysis
- ☐ Muscle weakness
- ☐ Numbness, Tingling
- ☐ Loss of Memory

EMOTIONAL
- ☐ Anxiety
- ☐ Depression
- ☐ Mental Illness
- ☐ Mood Swings
- ☐ Nervousness
- ☐ Temper Problems
- ☐ Tension

SLEEP:
- ☐ Insomnia

HEAD & NECK
- ☐ Headaches
- ☐ Head injury
- ☐ Lumps, swollen glands
- ☐ Goiter
- ☐ Pain, stiffness

OTHER
- ☐ AIDS
- ☐ Allergies of any kind
- ☐ Cancer
- ☐ Drug/Alcohol Treatment
- ☐ Herpes
- ☐ Hepatitis
- ☐ HIV Positive
- ☐ Organ Transplant
- ☐ Osteoporosis
- ☐ Polio
- ☐ Psychiatric Treatment
- ☐ Radiation Therapy

OTHER:

DIETARY HABITS

Please desribe what you typically eat for each meal_____

Breakfast_____
_____
_____
_____

Lunch_____
_____
_____
_____

Dinner_____
_____
_____
_____

Snacks_____
_____
_____

Time you normally eat: Breakfast_____ Lunch_____ Dinner_____

CLIENT_____

LIFESTYLE HISTORY

Do you smoke? __Yes __No If yes, how many per day?_____How long?_____
Have you quit smoking? ___Yes ___No If yes, when _____
Do you consume alcoholic beverages? ___Yes ___No
If yes: ___Wine ___Mixed Drinks ___Beer
How much and how often?_____
Sleep:
Average hours of sleep per night?_____ Do you feel this is enough sleep? ___Y ___N
Describe your sleep: ___Unbroken ___I wake up ____ times per night
Do you awake rested? ___Y ___N If no, explain _____
Describe any other difficulties or patterns with your sleep _____
_____
_____

Rate your energy level (5 being most energetic) 1 2 3 4 5
Rate your activity level:
___sedentary ___slightly active ___moderately active ___very active

STRESS
Rate your stress level (5 being most stressful) 1 2 3 4 5
Where does your stress come from: ____job ____family ___other (please explain)
_____

How much discretionary time do you have in your life?_____
How much time do you take for yourself each day and how do you use it? _____
_____
Do you take vacations and if so, how often? _____
Hobbies and leisure activities_____
_____
_____

EXERCISE:
Do you exercise? ____Yes ____No
If yes, how many days per week?_____ How long each session? _____
What type of exercise do you do?_____
_____
_____
_____

Do you have a religious affiliation? ___Y ___N
If yes, please indicate_____
Are you open to being prayed with? ___Y ___N
How would you describe your spiritual life_____
_____

CLIENT_____

DIET/NUTRITION

Please indicate how many servings *PER DAY* you have of each of the following: *For fruits and vegetables a serving is approximately 1/2 cup*

Fruit _____
Vegetables_____
Whole Grains, breads, cereals _____
Seeds/Nuts (i.e. pumpkin, sunflower, almonds, etc)_____
Dairy (milk, cheese, yogurt, etc.) _____

Please indicate how many servings *PER WEEK* you have of each of the following:

Meat (red, pork, lamb) _____
Lunchmeats _____
Poultry (chicken, turkey) _____
Fish _____
Shellfish_____

How much of the following to do you consume: (Indicate whether per day, week, etc.)

Regular Coffee_____
Decaffeinated Coffee_____
Do you use creamer? ___Y ___N Sweetener ___Y ___N
Tea_____
_____Herbal _____Black _____Green
Colas/sodas_____
Sugar substitutes/artificial sweeteners used_____
Sweets (ice cream, cookies, cakes, pastries, candies, chocolate, etc.) What type and how often do you consume them?_____
_____
How often do you eat out and what types of food?_____
_____
How often do you eat fried foods?_____
How often do you eat wheat products?_____
How much water do you drink per day?_____

PLEASE LIST SUPPLEMENTS YOU TAKE

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

CHOLESTEROL

If known, please complete the following:

TOTAL CHOLESTEROL

Less than 200 (optimal) 200-239 (borderline high) 240 and above (high)

My total cholesterol is _____

LDL/LOW DENSITY LIPOPROTEIN (Bad cholesterol)

My LDL cholesterol is _____

HDL/HIGH DENSITY LIPOPROTEIN (Good cholesterol)

My HDL cholesterol is _____

My HDL to Total Cholesterol Ratio is_____

TRIGLYCERIDES

<150 (optimal) 150-200 (border/high) 200-400 (high) 400 and above (very high)

My Triglycerides are _____

BLOOD PRESSURE

	Optimal	Normal	High Normal	Hypertension
Systolic	<120	<130	130-139	140 or higher
Diastolic	<80	<85	85-89	90 or higher

My blood pressure is _____/_____