Male Health History Questionnaire

(To be completed by patient)

We would like to take the time to thank you for choosing our office to assist you with your journey to optimal health. Our ability to draw effective conclusions about your state of health and how to optimize its improvement depends largely on the accuracy of the information in which you provide, including symptoms that you may consider minor. Health issues may be influenced by many factors; therefore, it is important that you carefully consider the questions asked in this form as well as those posed by the doctor during your consultation.

Name:_____ Date:_____

Current Health Status/Concerns

Please provide us with current and ongoing problems

Problem	Date of Onset	Severity/Frequency	Treatment Approach	Success
Example: Headaches	**May 2006**	**2 times per week**	**Acupuncture/Aspirin**	**Mild improvement**

What diagnosis or explanation(s), if any, have been given to you for these concerns?

_____

_____

_____

When was the last time that you felt well?_____

What seems to trigger your symptoms?_____

What seems to worsen your symptoms?_____

What seems to make you feel better?_____

What physician or other health care provider (including alternative or complimentary practitioners) have you seen for these conditions?_____

_____

_____

_____

How much time have you lost from work or school in the past year due to these conditions?_____

_____

Past Medical & Surgical History

If you have experienced a reoccurrence of an illness, please indicate when or how often under comments.

Illnesses	When /Onset	Comments
Anemia		
Arthritis		
Asthma		
C-Dif		
Cancer (specify type)		
Chicken Pox		
Chronic bacteria or fungal infections		
Cycling Disorder (PCOS, endometriosis, fibroids)		
COVID		
Crohn's Disease or Ulcerative Colitis		
Diabetes (all Types)		
Emphysema, COPD		
Epilepsy, convulsions, or seizures		
Gallstones		
Gout		
Heart Attack, Angina		
Hepatitis		
Herpes Lesions/Shingles		
High blood fats (cholesterol, triglycerides)		
High blood pressure (hypertension)		
Influenza		
IBS (or chronic diarrhea/constipation)		

Kidney stones		
Lyme		
Measle, Mumps, Rubella		
Mental Health Issue (OCD, ADD etc.)		
Mononucleosis or EBV		
Parasite Infection		
Pneumonia		
SIBO/SIFO		
Sleep Apnea		
Stroke (specify type)		
Thyroid (e.g. Graves, Hashimoto's)		
Other (describe)		

Injuries	When	Comments
Back injury		
Broken bones or fractures (describe)		
Head injury or Concussion		
Neck injury		
Other (describe)		

Diagnostic Studies	When	Comments
Biopsy (specify location)		
Bone Scan		
Carotid Artery Ultrasound		
CAT Scan (Please indicate type)		
Colonoscopy		
EKG		
Endoscopy		
Liver Scan		
Mammogram		
MRI		
Thermography		
X-Ray (Please indicate type)		
Other (describe)		

Surgeries	When	Comments
Ablation		
Appendectomy		
Gall Bladder		
Gender Reassignment Surgery		
Hernia		
Prostatectomy		
Tonsillectomy		
Tubes in Ears		
Vasectomy		
Other (describe)		

Hospitalizations

Where Hospitalized	When	Reason

Medications

How often have you taken antibiotics?	Less than 5 times	More than 5 times	Comments
Infancy/Childhood			
Teen			
Adulthood			

How often have you taken oral steroids? (e.g. Prednisone, Cortisone, etc.)	Less than 5 times	More than 5 times	Comments
Infancy/Childhood			
Teen			
Adulthood			

Are you allergic to any medication, vitamin, mineral, or other nutritional supplement?

Yes___ No ___
If yes, please list:_____

_____

Childhood History

Please answer to the best of your knowledge.

	Yes	No	Don't Know	Comment
Where you a full term baby?				
A premature birth? ('preemie')				
Breast fed?				
Bottle fed?				

When pregnant with you, did your mother:

Smoke tobacco?				
Use recreational drugs?				
Drink alcohol?				
Use estrogen?				
Other prescription or non-prescription medications?				

Immunization History

Please indicate if you have been vaccinated against any of the following diseases:	Yes	No	Don't Know	Comment (Any know adverse reactions)
Smallpox				
DTaP (Diphtheria, Tetanus, Pertussis)				
Polio (oral or injected)				
Hepatitis (specify type)				
MMR (Mumps, Measles, Rubella)				
Typhoid				
Cholera				
Shingles				
Influenza (Flu Shot)				
RSV				
HPV				
COVID (specify number of doses and maker)				

Childhood Diet

Was your childhood diet high in:	Yes	No	Don't Know	Comment
Sugar? (Sweets, Candy, Cookies, etc.)				
Soda?				
Fast food, pre-packaged foods, artificial sweeteners?				
Milk, cheeses, other dairy products?				
Meat, vegetables, & potato diet?				
Vegetarian diet?				
Diet high in white breads?				

As a child, were there foods that you had to avoid because they gave you symptoms? Yes___ No___

If yes, please explain: (Example: milk – diarrhea)_____

_____

Childhood Illnesses

Please indicate which of the following problems/conditions you experienced as a child (**ages birth to 12 years**) and the approximate age of onset.

	YES	AGE
ADD (Attention Deficient Disorder)		
Asthma		
Bronchitis		
Chicken Pox		
Colic		
Congenital problems		
Ear infections		
Fever blisters		
Frequent colds or flu		
Frequent headaches		
Hyperactivity		
Jaundice		

	YES	AGE
Mumps		
Pneumonia		
Seasonal allergies		
Skin disorders (e.g. dermatitis)		
Strep infections		
Tonsillitis		
Upset stomach, digestive problems		
Whooping cough		
Other (describe)		
Other (describe)		
Measles		

As a child did you: Have a high absence from school? Yes___ No___

If yes, why?_____

Experience chronic exposure to second hand smoke in your home? Yes___ No___
Experience abuse Yes___ No___ Have alcoholic parents? Yes___ No___

Male Medical History

Have you had a vasectomy? Yes___ No___
When? _____

Experienced any symptoms related to the vasectomy? Yes___ No___
If so, please explain: _____

_____

Reverse vasectomy? Yes___ No___
When? _____

Do you have any history of prostate problems? Yes___ No___
If so, please explain: _____

_____

When was your last prostate exam? _____

What were your most recent PSA results? _____
Date _____

Does your bladder always feel full? Yes___ No___ Sometimes___

When you have the urge to urinate, do you experience difficulty starting or stopping urine flow?
Yes___ No___ Sometimes___

Do you experience inconsistent pressure or pain during urination? Yes___ No___ Sometimes___

Do you experience frequent urination during the day or night? Yes___ No___
If so, please explain: _____

Do you experience low sex drive? Yes___ No___ Sometimes ____

Do you experience heightened sex drive? Yes___ No___ Sometimes____

Do you have difficulty obtaining an erection? Yes___ No___ Sometimes____

Do you have difficulty sustaining an erection? Yes___ No___ Sometimes____
If yes, how long before it starts to fade? _____

Do you have premature ejaculation? Yes___ No___ Sometimes____

Does ejaculation cause pain? Yes___ No___ Sometimes ___

Family Health History

Please indicate current and past family history to the best of your knowledge

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Age (if still living)									
Age at death (if deceased)									
Heart Attack									
Stroke									
Uterine Cancer									
Colon Cancer									
Breast Cancer									
Ovarian Cancer									
Prostate Cancer									
Skin Cancer									
ADD/ADHD									
ALS or other Motor Neuron Diseases									
Alzheimer's									
Anemia									
Anxiety									
Arthritis									
Asthma									
Autism									
Autoimmune Diseases									
Bipolar Disease									
Bladder disease									
Blood clotting problems									
Celiac disease									
Dementia									
Depression									
Diabetes									
Eczema									
Emphysema									
Environmental Sensitivities									
	Fat.	Mot.	Bro	Sis	Chil	Mate	Mat	Pat	Pate

Check Family Members that Apply									
Epilepsy									
Flu									
Genetic Disorders									
Glaucoma									
Headache									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis)									
Inflammatory Bowel Disease									
Insomnia									
Irritable Bowel Syndrome									
Kidney disease									
Multiple Sclerosis									
Nervous breakdown									
Obesity									
Osteoporosis									
Other									
Parkinson's									
Pneumonia/Bronchitis									
Psoriasis									
Psychiatric disorders									
Schizophrenia									
Sleep Apnea									
Smoking addiction									
Substance abuse (such as alcoholism)									
Ulcers									

Dental History

	Yes	No
Problem with sore gums (gingivitis)?		
Ringing in the ears (tinnitus)?		
Have TMJ (temporal mandibular joint) problems?		
Metallic taste in mouth?		
Problems with bad breath (halitosis) or white tongue (thrush)?		
Previously or currently wear braces?		
Problems chewing?		
Floss regularly?		
Do you have amalgam dental fillings? How many?		
Did you receive these fillings as a child?		

List your approximate age and the type of dental work done from childhood until present:

Age	Type of dental work:	Health Problems following dental work? (describe)

Nutritional History

Have you made any changes in your eating habits because of your health? Yes____ No_____

If yes, when did you make these changes? _____

How much of the following do you consume each week?

Candy	
Cheese	
Chocolate	
Cups of coffee containing caffeine	
Cups of decaffeinated coffee or tea	
Cups of hot chocolate	
Cups of tea containing caffeine	
Diet soda	
Ice cream	
Salty foods	
Slices of white bread (rolls/bagels, etc.)	
Soda with caffeine	
Soda without caffeine	

Do you currently follow a special diet or nutritional program? Yes____ No_____

- ❑ Ovo-lacto
- ❑ Diabetic
- ❑ Dairy restricted
- ❑ Other (describe)_____
- ❑ Vegetarian
- ❑ Vegan
- ❑ Blood type diet

Please tell us if there is anything special about your diet that we should know._____

_____

Do you have symptoms ***immediately after*** eating, such as belching, bloating, sneezing, hives, etc.?
Yes___ No____
If yes, are these symptoms associated with any particular food or supplement? Yes___ No____
If yes, please name the food or supplement and symptom(s). _____

_____

Do you feel that you have ***delayed*** symptoms after eating certain foods, such as fatigue, muscle aches, sinus congestion, etc.? (symptoms may not be evident for 24 hours or more)
Yes___ No____

Do you feel **worse** when you eat a lot of:

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Other_____

Do you feel **better** when you eat a lot of:

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Other_____

Does skipping meals greatly affect your symptoms? Yes _____ No _____

Has there ever been a food that you have craved or 'binged' on over a period of time?

Yes _____ No _____ If yes, what food(s) _____

_____

Do you have an aversion to certain foods? Yes _____ No _____

If yes, what food(s) _____

_____

Please complete the following chart as it relates to your bowel movements:

Frequency	√	**Color**	√
More than 3x/day		Medium brown consistently	
1-3x/ day		Very dark or black	
4-6x/week		Greenish color	
2-3x/week		Blood is visible	
1 or fewer x/week		Varies a lot	
		Dark brown consistently	
Consistency	√	Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	
Often floats			
Difficult to pass			
Diarrhea			
Thin, long or narrow			
Small and hard			
Loose but not watery			
Alternating between hard and loose			

Lifestyle History

Tobacco History

Have you ever used tobacco? Yes ____ No _____

If yes, what type? Cigarette ___ Smokeless ___ Cigar ___ Pipe ___ Patch/Gum ___How much?___

Number of years?_____If not a current user, year quit_____

Attempts to quit: _____

Are you exposed to 2nd hand smoke regularly? If yes, please explain:_____

_____

Alcohol Intake

Have you ever used alcohol? Yes____ No____

If yes, how often do you now drink alcohol?

- ❑ No longer drink alcohol
- ❑ Average 1-3 drinks per week
- ❑ Average 4-6 drinks per week
- ❑ Average 7-10 drinks per week
- ❑ Average >10 drinks per week

Do you notice a tolerance to alcohol (can you "hold" more than others?) Yes____ No____

Have you ever had a problem with alcohol? Yes____ No____

If yes, indicate time period (month/year) From_____ to _____

Other Substances

Do you currently or have you previously used recreational drugs? Yes____ No____

If yes, what type(s) and method? (IV, inhaled, smoked, etc.)_____

_____

To your knowledge, have you ever been exposed to toxic metals in your job or at home? Yes___No___

If yes, indicate which

- ❑ Lead
- ❑ Arsenic
- ❑ Aluminum
- ❑ Cadmium
- ❑ Mercury

Sleep & Rest History

Average number of hours that you sleep at night? Less than 10__ 8-10___ 6-8___ less than 6___

Do you:

- ❑ Have trouble falling asleep?
- ❑ Feel rested upon wakening?
- ❑ Snore?
- ❑ Have problems with insomnia?
- ❑ Use sleeping aid?

Exercise History

Do you exercise regularly? Yes____ No____

If yes, please indicate:	Times/week				Length of session			
Type of exercise	1x	2x	3x	4x/+	≤15	16-30 min	31-45 min	>45
Jogging/Walking								
Aerobics								
Strength Training								
Pilates/Yoga/Tai Chi								
Sports (tennis, golf, water sports, etc.)								
Other (please indicate)								

If no, please indicate what problems limit your activity (low motivation, fatigue after exercising, etc.)

_____

_____

Social History

Because stress has a direct effect on your overall health and wellbeing that often leads to illness, immune system dysfunction, and emotional disorders, it is important that your health care provider is aware of any stressful influences that may be impacting your health. Informing your doctor allows him/her to offer you supportive treatment options and optimize the outcome of your health care.

Stress/Psychosocial History

Are you overall happy? Yes____ No____

Do you feel you can easily handle the stress in your life? Yes ____ No _____

If no, do you believe that stress is presently reducing the quality of your life? Yes____ No____

If yes, do you believe that you know the source of your stress? Yes____ No____

If yes, what do you believe it to be?_____

Have you ever contemplated suicide? Yes____ No____

If yes, how often? _____ When was the last time?_____

Have you ever sought help through counseling? Yes____ No____

If yes, what type? (e.g. psychologist, counselor, etc.)_____

Did it help?_____

How well have things been going for you?

	Very well	Fine	Poorly	Very poorly	Does not apply
At school					
In your job					
In your social life					
With close friends					
With sex					
With your attitude					
With your boyfriend/girlfriend					
With your children					
With your parents					
With your spouse					

Which of the following provide you emotional support? *Check all that apply*

❑ Spouse ❑ Family ❑ Friends ❑ Religious Spiritual ❑ Pets ❑ Other _____

Have you ever been involved in abusive relationships in your life? Yes ___ No___

Have you ever been abused, a victim of a crime, or experienced a significant trauma? Yes__ No___

Did you feel safe growing up? Yes ___ No___

Was alcoholism or substance abuse present in your childhood home? Yes ___ No___

Is alcoholism or substance abuse present in your relationships now? Yes ___ No___

How important is religion (or spirituality) for you and your family's life?

a. _____ not at all important b. _____ somewhat important c. _____ extremely important

Do you practice meditation or relaxation techniques? Yes ___ No ___

If yes, how often? _____

Check all that apply:

❑ Yoga ❑ Meditation ❑ Imagery ❑ Breathing ❑ Tai Chi ❑ Prayer ❑ Other

Hobbies and leisure activities, what do you do for fun:

_____

_____

Is there anything that you would like to discuss with the doctor today that you feel was not covered on this form?

Comments _____

_____

_____

Thank you for taking the time to complete this health history medical questionnaire. The information derived from all of these forms will provide invaluable data in identifying the underlying problems of your health concerns rather than simply treating the symptoms alone.

We look forward to helping you achieve lifelong health and wellbeing.

Yours in Health,

Dr. Annette Kutz Schippel

This questionnaire is an adaptation of the Comprehensive Health History created by Wayne L. Sodano, D.C., D.A.B.C.I. and Ron Gristanti, D.C., D.A.B.C.O., M.S. at the Functional Medicine University. Sequoia Education Systems, Inc.

HIPAA Right of Access Form for Family Member/Friend

I, _____, direct Dr. Annette Kutz Schippel and Endocrine Wellness to disclose and release my protected health information described below to:

Name: _____ Relationship:_____

Contact information: _____

_____

Health Information to be disclosed upon the request of the person named above (Check one):

- ❑ Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR
- ❑ Disclose my health record, as above, BUT do not disclose the following (check as appropriate):
  - ❑ Mental health records
  - ❑ Communicable diseases (including HIV and AIDS)
  - ❑ Alcohol/drug abuse treatment
  - ❑ Other (please specify): _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ❑ An electronic record
- ❑ Hard copy

This authorization shall be effective until (Check one):

- ❑ All past, present, and future periods, OR
- ❑ Date or event:_____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers.)

_____ _____

Name of Individual Giving Authorization Date

_____

Signature

