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Adult Male Questionnaire

Today's Date: _____/_____/_____ BLOOD TYPE:____________

Patient Name: ____________________________ Birth date: ____/____/____ Age:_______
Address: ____
City: ____State: ________ Zip: ________
Home Phone: _____________________Cellular_________________Work:_______________
Email: ________________________
Type of Health Insurance: PPO____ HMO____ Other________________________
Occupation:___________________________________ Social Security #________________
Previous Occupations: ____
Single_____ Married_____ Widowed_____ Divorced_____

Height: _______ Weight: ________

- Do you use tobacco? _____ Yes How much per day?__________________ _____ No
- Do you use alcohol? _____ Yes How much per day?__________________ _____ No
- Do you use caffeine? _____ Yes How much per day?__________________ _____ No
- Tea, Coffee or Chocolate? ____
- **Do you use artificial sweeteners?** _____ Yes What type?______________ _____ No
- Do you drink carbonated beverages?_____ Yes How many per day? ________ _____ No
- Do you have any pets?_____ Yes Type? ___________________________ _____ No
- Have you lived or traveled outside of the United States?
  If so, when and where?

Allergies: Please check all that apply

_____ Penicillin _____ morphine _____ dye allergies _____ seasonal (pollen) allergies
_____ Codeine _____ aspirin _____ nitrate allergy _____ no known allergies
_____ sulfa drugs _____ food allergies _____ pet allergies _____ other: ____________________

Please describe the allergic reaction you experienced and when it occurred: __________________________
____

Over-the-counter (OTC) issues: Please check all products that you used occasionally or regularly.

_____ pain reliever
_____ aspirin
_____ acetaminophen (Tylenol®)
_____ ibuprofen (Motrin IB®)
_____ naproxen (Aleve®)
_____ ketoprofen (Orudis KT®)
_____ cough suppressant (Robitussin DM®)
_____ antihistamine (Benadryl, Chlor-Trimeton®)
_____ decongestant (Sudafed®)
____ combination products (cough & cold reliever, Triaminic DM®)
____ sleep aids (Excedrin PC®, Unisom®, Sominex®, Nytol®)
____ antidiarrheals (Imodium®, Pepto Bismol®, Kaopectate®)
____ Laxatives / stool softener (Doxidan®, Correctol®)
____ Diet aids / weight loss products (Dexatrim®
____ antacids (Maalox®, Mylanta®)
____ acid blockers (Tagamet HB®, Pepcid C®, Zantac 75®)
____ others: ______________________________

Vitamin/Mineral Supplements You Are Taking **Date Started** **Dosage**

Describe your eating habits including the times you usually eat: **(include deserts)**

Breakfast **Lunch** **Dinner** **Type of Snacks**

What foods to you crave?

Medical Conditions / Diseases: **Please check all that apply to you.**

______ Heart disease
______ High cholesterol or lipids (e.g. hyperlipidemia)
______ High blood pressure (e.g. hypertension)
______ Cancer
______ Ulcers (e.g. stomach, esophagus)
______ Thyroid disease
______ Hormonal related issues
______ Lung conditions (e.g. asthma, emphysema, COPD)
______ ***Other:***

_____ Blood clotting problems
_____ Diabetes
_____ Arthritis or joint problems
_____ Depression
_____ Epilepsy
_____ Headaches/migraines
_____ Eye disease (e.g. glaucoma, etc.)
_____ Thyroid disease - goiter, nodules, low thyroid

Please describe any past medical history:

Past Surgeries:

Current Prescription Medications:

Medication Name	Reason for Taking?	Strength	Date Started

How often have you taken antibiotics? ____

Hormones previously taken	Date Started	Date Stopped	Reason

Dental History

How many Silver/Mercury Amalgams do you have? ____________________

Recent cavities, crowns, root canals? Describe:____

____

History of any Gum Disease? Describe:____

Do you have a family history of any of the following?

Enlarged Prostate	_____ No	_____ Yes	Family member(s) ___________________
Prostate Cancer	_____ No	_____ Yes	Family member(s) ___________________
Other Cancers	_____ No	_____ Yes	Family member(s) ___________________
Heart disease	_____ No	_____ Yes	Family member(s) ___________________
Osteoporosis	_____ No	_____ Yes	Family member(s) ___________________
Diabetes	_____ No	_____ Yes	Family member(s) ___________________
Hypertension	_____ No	_____ Yes	Family member(s) ___________________
Allergies/Asthma	_____ No	_____ Yes	Family member(s) ___________________
Alzeimer's/Dementia	_____ No	_____ Yes	Family member(s) ___________________
Eczema	_____ No	_____ Yes	Family member(s) ___________________

Any other family history we should know about?____

____

Please indicate your symptoms for the following conditions:

	ABSENT	MILD	MODERATE	SEVERE
Prostate problems	________	________	___________	________
Weight Gain	________	________	___________	________
Carbohydrate Craving	________	________	___________	________
Chocolate Craving	________	________	___________	________
Constipation	________	________	___________	________
Dry Skin / Hair	________	________	___________	________
Anxiety	________	________	___________	________
Depression	________	________	___________	________
Night Sweats	________	________	___________	________
Headaches/Migraines	________	________	___________	________
Irritability	________	________	___________	________
Mood Swings	________	________	___________	________
Sleep Disturbances / Insomnia	________	________	___________	________
Fluid Retention	________	________	___________	________
Fatigue	________	________	___________	________
Memory Loss	________	________	___________	________
Incontinence/frequent urination	________	________	___________	________
Arthritis	________	________	___________	________
Decreased libido	________	________	___________	________
Hair Loss	________	________	___________	________
Thyroid Goiter	________	________	___________	________
Heartburn/Indigestion	________	________	___________	________
Diarrhea	________	________	___________	________
Gas/Bloating	________	________	___________	________

Lifesyle Questions

1. How often do you exercise?____

2. During the past 12 months, how often have you felt excessive stress in your life?

Never_____ Occasionally_____ Often_____ Almost always_____

Have you experienced any major losses in life? Yes____ No____

If so, please comment:

3. How would you describe your health?

Excellent_____ Very good_____ Good_____ Fair_____ Poor_____

ADAM Questionnaire

The ADAM questionnaire was developed by a physician and is used extensively by healthcare providers to help identify men who may have low testosterone.

Question	Yes	No
1. Do you have a decrease in libido (sex drive)?	○ Yes	○ No
2. Do you have a lack of energy?	○ Yes	○ No
3. Do you have a decrease in strength and/or endurance?	○ Yes	○ No
4. Have you lost height?	○ Yes	○ No
5. Have you noticed a decreased "enjoyment of life?"	○ Yes	○ No
6. Are you sad and/or grumpy?	○ Yes	○ No
7. Are your erections less strong?	○ Yes	○ No
8. Have you noticed a recent deterioration in your ability to play sports?	○ Yes	○ No
9. Are you falling asleep after dinner?	○ Yes	○ No
10. Has there been a recent deterioration in your work performance?	○ Yes	○ No

Describe your problems that lead you to this consultation:

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What are your goals with this consultation?

____

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Please write down any specific questions you may have.

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If possible, please fax or mail any recent lab work or other test results