

Health Review Form – Male

Name _____

Health Habits

Do you drink alcohol?	Yes	No	If yes, how much each day?	_____
Do you smoke cigarettes?	Yes	No	If yes, how many packs per day?	_____
Do you smoke a pipe or cigars?	Yes	No	If yes, how many per day?	_____
Do you drink coffee?	Yes	No	If yes, how many cups each day?	_____
Do you drink tea?	Yes	No	If yes, how many cups each day?	_____
Do you use other drugs?	Yes	No	If yes, which?	_____
How many hours do you sleep during an average night?	_____			
Who lives in your home with you?	_____			

Are you working? If so, where?

Health Review

Do you have any of the following? Check all that apply.

GENERAL

_____ Unintentional weight gain or loss
_____ Fever
_____ Fatigue
_____ Night sweats
_____ Loss of appetite
_____ Difficulty sleeping

EYE

_____ Blurry or double vision
_____ Loss of vision

EAR, NOSE, and THROAT

_____ Hearing problems
_____ Ringing in your ears
_____ Sinus problems
_____ Difficulty swallowing
_____ Neck swelling
_____ Hoarseness

HEART

_____ Chest pain
_____ Rapid or irregular heart beat
_____ Passing out or loss of consciousness
_____ Swollen feet

LUNGS

_____ Shortness of breath
_____ Cough
_____ Wheezing
_____ Coughing up blood

GASTROINTESTINAL

_____ Hemorrhoids
_____ Nausea or vomiting
_____ Heartburn
_____ Diarrhea
_____ Constipation
_____ Blood in stool
_____ Black tarry stool
_____ Change in bowel habits

MUSCULOSKELETAL

_____ Joint pain
_____ Joint swelling

URINARY

_____ Incontinence
_____ Urgency
_____ Burning on urination
_____ Difficulty urinating
_____ Blood or mucus in urine
_____ Frequent urination
_____ Sores on penis
_____ Discharge from penis
_____ Pain or lump on testicles
_____ Difficulty attaining or maintaining erections

SKIN

_____ Moles that you are concerned about
_____ Rash
_____ Itching

NEUROLOGICAL

_____ Dizziness
_____ Numbness
_____ Weakness
_____ Tremor
_____ Unsteady while walking

ENDOCRINE

_____ Swelling of hands or fingers
_____ Excessive thirst
_____ Large amount of urine

LYMPHATIC/HEMATOLOGICAL

_____ Swollen glands
_____ Bruise easily
_____ Sores that do not heal

PSYCHOLOGICAL

_____ Anxiety
_____ Depression
_____ Panic attacks

ALLERGIC/IMMUNOLOGIC

_____ Sneezing
_____ Watery eyes

SEXUAL HISTORY

_____ 5 or more sexual partners (during lifetime)
_____ Sexual activity before age 16