MALE adult **Health History Summary** Date_____

Name_____ Age_____ Birthdate_____ Blood type_____

Address_____ City_____ State____ Zip_____

Phone (home)_____ (work)_____ (cell) _____

Email: _____ Soc Sec # _____

Occupation_____ (full/part time?) Employer_____

Insurance Co._____ Policy #_____ Phone # _____

Nearest Relative_____ Phone_____
what is their relationship to you?

Who else can we contact in case of emergency?_____ Phone_____
what is their relationship to you?

How did you hear about the Tabor Hill Clinic? _____

Last physician or health practitioner seen/phone?_____ When? _____

When was your last blood test?_____ What kind(s)? _____

Your Current Health Problems
What is your **main** reason for coming in today? If you have a specific health condition please describe in detail. When was the very first time that you noticed your condition and describe carefully any factors that you suspect may have played a role in its onset and its continuation.

List in order of importance other health problems that are troubling you:

1)_____ & length of time_____

2)_____ & length of time_____

3)_____ & length of time_____

4)_____ & length of time_____

Other problems:_____

How long has your **main** problem been troubling you?_____

Is your current "main problem" getting *[better, worse, same]* and for how long?_____

What kind of treatment have you received and from whom?_____

Have you ever seen a naturopathic physician, chiropractor, acupuncturist or other alternative health practitioner for your current problem? ***(yes or no)*** or for any problem? ***(yes or no).***

What was the therapy and what were the results?_____

_____

Your Health History

The general state of your health is: **(excellent___) (good___) (avg___) (fair___) (poor___),**

and on the average describe your energy level from 1-10 (10 is highest & 1 lowest) "_____"

When during the day is your energy the best?_____ worst?_____

What is your current approximate weight?_____ height?_____ Weight one year ago_____

As an adult your max. Wt?_____date_____ (not include pregnancy) and lowest. wt._____date_____

Please list the 5 most significant, stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? ***(yes or no) Please circle***

1) _____date_____

2) _____date_____

3) _____date_____

4)_____ date_____

5)_____ date_____

Are you currently working with a professional counselor, psychologist, social worker, pastor or other therapist?_____ Have you in the past?_____ If so when?(give dates)_____

Are you currently working with a Doctor of conventional medicine?(M.D. or D.O.)***(Yes or No)***

What childhood illnesses have you had? (check off if had)

measles _____	mumps_____	chickenpox_____	whooping cough____
polio _____	diphtheria_____	rheumatic fever_____	scarlet fever_____
smallpox_____	typhoid fever_____	tuberculosis_____	mono___ how long__

Previous surgeries and hospitalizations (include dates)_____

_____

Which of the following have you had and indicate "now or past";.& also how often and when.

now or past	year	now or past	year	now or past	year
____pneumonia	_____	____diabetes_____		_____gonorrhea_____	
____tonsillitis	_____	____asthma	_____	_____syphilis	_____
____ear infections	_____	____eczema_____		_____venereal disease	____
____chronic infections_____		____heart disease____		_____epilepsy	_____
____canker sores	_____	____herpes_____		_____high blood pressure____	
____allergies_____		____hepatitis_____		_____mononucleosis____	
____thyroid problems_____		____weight prob.____		_____anemia	_____
____auto immune disease___		____cancer_____		_____others_____	

Do you have any allergies to any drugs, herbs, foods, animals or other? ***(Y or N)*** What? _____

Which of the following do you currently use?

amount (how often, how much & how long) amount (how often, how much & how long)

alcohol _____ tobacco_____

hormones _____ marijuana_____

cortisone_____ coffee_____

sedatives or sleep aids _____ laxatives_____

_____ antacids_____

Have you ever had a drug or alcohol problem?_____Now or in past?_____

other medications (please give full name and doseage and how long have you been taking the medication)

_____/ _____/ _____

_____/ _____/ _____

_____/ _____/ _____

vitamins\herbs_____/ _____/_____/_____

_____/ _____/ _____/ _____/ _____

_____/ _____/ _____/ _____/ _____

Family History

Please list ages, health problems and if deceased, cause of death:

	Living(age?)	Health Problems	Died (age?)	Cause
Your Mother	_____	_____	____	_____
Your Father	_____	_____	____	_____
Your Brothers	_____	_____	____	_____
	_____	_____	____	_____
	_____	_____	____	_____
Your Sisters	_____	_____	____	_____
	_____	_____	____	_____
	_____	_____	____	_____
Grandmom & granddad Mother's Mom	_____	_____	____	_____
Mother's Dad	_____	_____	____	_____
Grandmom & granddad Father's Mom	_____	_____	____	_____
Father's Dad	_____	_____	____	_____

What is your nationality? *(please list all backrounds & give approximate %)*_____

_____

You currently live with? spouse___ partner___ parents___ friends___ children___ alone____

Are you? married____ separated___ divorced___ widowed___ single___ in a supportive relationship___

What is your current level of education?_____ Are you satisfied with this? ***(Yes or No)***

Do you have any children?_____ How many? _____ What are their ages?_____

Do they have any health problems?_____

Do you have any blood relative aunt uncle or grandparent who has had any of the following?

____allergies	____arthritis	____asthma	____cancer	____diabetes
____anemia	____depression	____skin disease	____heart attack	____genetic prob
____High B.P.	____stroke	____ulcers	____cataracts	____thyroid prob
____hypoglycemia	____seizures	____sickle cells	____venereal disease	

What is your weakest organ system and why?_____

Personal Habits

What do you enjoy most in your life?_____

What are your main interests or hobbies?_____

What do you worry most about in life?_____

What is the single most important thing to you in your life?_____

What are your life goals?_____

Do you exercise? ***(yes/no)*** If yes what kind, how much & how often?_____

Do you have a religious or spiritual practice? (***Yes/No***) If yes, what?_____

On a scale of 1-10, how would you rate the quality of your sleep (10 being great) _____

Do you have problems (*falling or staying asleep)*? ____ How many hrs do you sleep?_____

Do you awaken at night? ***(yes or no)*** If yes what time(s) do you usually wake up?_____

Do you ever sweat at night while sleeping? ***(yes or no)***. How frequently and how much do you sweat?_____ Do you wake up feeling refreshed? ***(yes or no)***

Do you nap or rest horizontally throughout the day? ***(yes or no)***. For how long? _____

Do you enjoy your work? **(*yes or no)*** Do you take vacations? **(*yes or no*)**

Are you currently in a happy satisfying relationship with someone? ***(Very, mostly, somewhat, not)***

How often do you get colds, flus, sore throat, yeast infections during the year?_____

When you rise quickly from a sitting or lying position do you ever get dizzy? ***(yes or no)*** *If yes how often?****(daily; few times per week; 1x week; 2x per month; 1x per month; rarely)***

Male Reproduction

Do you have to get up at night to urinate?____ *If yes how often?*_____ Is this an increase recently*?(Y/N)*

Any problems with impotency? (getting or maintaining an erection) ***(Y/N).*** Have you had a decrease in your libido (sex drive) in last few years? ***(Y/N).*** If yes, over what period of time?_____

Currently where is your libido at? (10 being the highest and 0 lowest) _____

Have your erections become less hard? ***(Y/N).*** Have you had difficulty maintaining erections once achieved? ***(Y/N).*** Do you need to take medications such as Viagra, Levitra or Cialis to achieve adequate erections? ***(Y/N).*** What dosage of medication do you require?_____

Have you ever taken testosterone? ***(Y/N)***. Have you had your testosterone levels measured? ***(Y/N)*.**

Have you noticed a decrease in muscle mass in the last few years? ***(Y/N)*** *Have you noticed a decrease in strength, endurance, or memory in the last few years?* ***(Y/N)***

Any sores on penis? ***(Y/N)*. past or present?** Do you have any abnormal discharge from the penis? ***(Y/N)***

Any veneral diseases? **(*yes or no)*** Any prostate problems? **(Y/N & *past/now)*** Ever have your prostate examined?(Y/N). When?_____

Are you currently sexually active?***(Y/N)*** How often?_____ Is this ***(more or less)*** than 1 yr ago?

Do you use birth control? ***(Y or N)*** What type of birth control do you currently use?_____

Have you ever been physically or sexually abused? ***(Y/N)*** How old and how often?_____

Digestion and Elimination

Digestion *(circle or fill in the answer)*

Do you have any problems with gas, bloating or fullness after eating? (**Yor N**). How often do you have gas, fullness or bloating after eating? ***(often, sometimes, never)***. How severe?_____ Do you have gas in ***(the upper part of the abdomen or lower part or both areas)***?

How long have you had this problem?_____

How often do you have bowel movements?_____

Do you ever have any **(blood, mucus, undigested food, black stools)**?

Any rectal itching? **(Y/N)** Do your stools tend to be ***(formed or loose)***? How often do you have loose stools or diarrhea?_____Do you ever have alternating constipation and diarrhea? **(Y N)**

How often do you have thin, long and narrow stools? ***(often sometimes never)***

How often do you have small & hard stools?***(often, sometimes, never)***

Do you ever have yellow or light colored stools? ***(often, sometimes, never)***

How often do your stools have a strong disagreeable odor? ***(often, sometimes, never)***

Have you ever fasted? ***(yes or no; juice or water)*** For how long have you fasted?_____

How did you feel while you were fasting?_____

Have you traveled outside the U.S. in last 5 years? ***(Y/N)*** *Have you gone camping in last 5 yrs?****(Y/N)***

Have you ever had an eating disorder now or past such as anorexia or bulimia? (Y N)

What do you normally feel like temperature wise, compared to others? ***(warm or cooler or avg)***

What are the temperatures of your hands and feet generally? ***(warmer or cooler or average)***

Do you have difficulty perspiring? ***(Y N)***.. Do you perspire when you exercise? ***(lightly, moderately, heavily)***. Do you perspire other times than when exercising? ***(Y N)*** When?

Does your perspiration have a strong smell? ***(Yes or No)***

Kidneys and bladder

Have you had recurrent bladder infections?***(Yes or No)*** How were they treated?_____

How many bladder infections have you had in the last 3 years?_____

Do you have any burning sensation during or after urination? ***(Past or Present or now)***

Is your urine ***(dark yellow, bright yellow, cloudy, pale or clear)****?*

Does your urine have a strong odor to it? ***(Yes or No)***

Do you have difficulty starting or stopping when urinating? ***(Yes or No)***

Occupational/household

How long have you lived at your present address?_____

Where have you lived previously? _____

(Please describe location, if old or new place, i.e., new construction, damp or moldy)

_____

Do you have specialized air filtration at home? ***(yes or no)*** *Do you live in city?* ***(Yes or No)***

Do you work in an office building? ***(yes or no)*** Do the windows open? ***(yes or no)***

Do you have specialized air filtration at your work place? ***(yes or no)***

Do you work in the presence of toxic fumes or chemicals? ***(yes or no)***

Do any of your hobbies involve toxic materials? ***(yes or no)***

Are you exposed to second hand smoke currently? ***(yes or no)***

What do you use for your drinking water? ***(bottled, filtered, or tap water)***

Dental

How often do you see a dentist?_____ Do you have a regular dentist that you like? ***(yes or no)***

How often do you get your teeth cleaned?_____ How many silver fillings do you have in mouth?____

Have you ever had any root canals?_____ Do you have any ongoing problems with your teeth including pain, discomfort or jaw pain?_____

Do you still have any wisdom teeth in your mouth?

What are your immediate health goals?_____

How long do you want to live?_____ How long do you expect to live to?_____

Was this health history summary (too long, too short or just right)

Do you have anything else you would like to comment on? _____