Functional Health Institute

MALE HEALTH HISTORY

Patient Name: _____

Please take your time in filling out these forms
as honestly and accurately as possible.

PLEASE SELECT THE FREQUENCY OF CONSUMPTION OF THE FOLLOWING:

Soda or carbonated beverages:	○ Daily	○ Few /Week	○ Few /Month	○ Never
White flour products:	○ Daily	○ Few /Week	○ Few /Month	○ Never
Fried foods:	○ Daily	○ Few /Week	○ Few /Month	○ Never
Coffee:	○ Daily	○ Few /Week	○ Few /Month	○ Never
Fast foods:	○ Daily	○ Few /Week	○ Few /Month	○ Never
Sweets / refined carbohydrates:	○ Daily	○ Few /Week	○ Few /Month	○ Never
Beer / wine:	○ Daily	○ Few /Week	○ Few /Month	○ Never
Hard alcohol:	○ Daily	○ Few /Week	○ Few /Month	○ Never
Tobacco products:	○ Daily	○ Few /Week	○ Few /Month	○ Never

Are you a vegetarian: ○ Yes ○ No

Are you currently involved in an exercise program: ○ Yes ○ No

Please list any allergies:

History:

Please select if you have or ever had any of the following:

☐	Anemia	☐	Herpes Simplex, Fever Blisters, Cold Sores
☐	Appendicitis	☐	High blood pressure
☐	Arthritis	☐	Kidney infection
☐	Cancer (specify)	☐	Liver problems
☐	Chronic bronchitis	☐	Loss of balance
☐	Chronic headaches	☐	Neurological problems
☐	Colitis	☐	Parasitic infections
☐	Diabetes	☐	Pneumonia
☐	Gall bladder problems	☐	Seizures
☐	Heart disease	☐	Thyroid problems
☐	Hepatitis	☐	Ulcers

Male Health History:

If you have children, please list their ages: _____

Have you had a vasectomy? ○ Yes ○ No Year: _____

Please explain any symptoms related to the vasectomy:

_____

_____

Have you had a reverse vasectomy: ○ Yes ○ No Year: _____

When was your last prostate exam? _____

Does your bladder always feel full: ○ Yes ○ No ○ Sometimes

What were your most recent PSA results? _____ Date: _____

Does ejaculation cause pain? ○ Yes ○ No ○ Sometimes

Do you have premature ejaculation: ○ Yes ○ No ○ Sometimes

SLEEP:

Number of hours you typically sleep each night: _____ Do you sleep well? ○ Yes ○ No

Do you keep your room completely dark at night? ○ Yes ○ No

SURGERIES, ACCIDENTS, TRAUMAS: Please list any you have had and include dates.

_____

_____

_____

_____

_____

_____