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Confidential Health History

Date _____.

Name _____ Age _____ Date of Birth _____.

Phone(s) _____ Email _____.

☐ Married ☐ Single ☐ Widowed Name of partner _____.

Primary Physician _____RE or Urologist _____.

Date of your last physical exam? _____ By whom? _____.

Main reasons for today's visit:

_____.

_____.

When did this begin? _____.

What makes it better? _____.

What makes it worse? _____.

What treatment have you received? _____.

Were you given a diagnosis? _____.

Does anyone in your family have the same problem? _____.

If you have pain is it: ☐ slight ☐ moderate ☐ severe ☐ constant ☐ comes & goes
☐ sharp ☐ dull ☐ aching ☐ burning ☐ throbbing

Does it interrupt your daily activities? _____ Quality of life? _____.

Any other health issues? _____.

_____.

Current Medications _____.

_____.

Herbs or Supplements _____.

_____.

Surgeries or Hospitalizations (list dates) _____.

_____.

Physical or Emotional Trauma, Injuries _____.

_____.

Allergies (food sensitivities, drug reactions, etc.)_____.

_____.

Personal Medical History: Please check any you have had now or in the past. Add others if needed.

	Mumps		Arthritis		Cancer
	Measles		Fibromyalgia		Heart Disease
	Chicken Pox		Eating Disorder		Pacemaker
	Pneumonia		Liver Disease		High or Low Blood Pressure
	Tuberculosis		Gallstones		Stroke
	Rheumatic or Scarlet Fever		Ulcers		High Cholesterol
	Mononucleosis		Gout		Seizures
	Herpes		Alcoholism		Bleeding Disorder
	Hepatitis B or C		Diabetes		Anemia
	Epstein-Barr Virus		Hypoglycemia		Raynaud's Disease
	AIDS/HIV		Faint easily		Impotence
	Emphysema		Ear infections		Infertility
	Asthma		Kidney Disease		Prolapsed Organ
	Allergies		Kidney Stones		Chronic Fatigue Syndrome
	Eczema		Hypo-Thyroidism		Concussion
	Lyme Disease		Hyper-Thyroidism		ADD or ADHD
					Osteopenia or Osteoporosis
	Auto-immune Disease –				

How often have you taken antibiotics and when? _____.

_____.

Family Medical History:

Please mark **F** – father **M** – mother **S** – sister **B** – brother **GM** or **GF** – grandparents

Asthma		Heart Disease		Strokes	
Diabetes		High or Low Blood Pressure		Seizures	
Cancer		Thyroid Conditions		Infertility	
Alcoholism		High Cholesterol		Miscarriage	
Allergies		Auto-immune Diseases		Bleeding Disorder	
Obesity		Osteoporosis		Depression	

Family Member	Age	Health – Excellent, Good, Poor	Age at Death	Cause of Death
Mother				
Father				
Sisters				
Brothers				
Spouse/Partner				
Children				

Lifestyle:

Do you eat at regular mealtimes? _____ # meals a day _____.

Foods you eat often _____.

Foods you avoid _____.

Average Day	Time	Foods eaten
Breakfast		
Lunch		
Dinner		
Snacks		

Glasses of water a day _____ Sodas _____ Coffee_____ Black tea _____.

Alcohol _____ a day or _____a week What kind? _____.

Do you smoke? ☐ no ☐ yes # _____ a day . When did you start? _____.

Height _____ Weight _____ Max/min_____/_____ When?_____/_____.

What is your occupation? _____.

How do you relax? _____.

Types of exercise you enjoy, how often?_____.

How long is your commute? _____ Do you travel frequently? _____.

Do you feel your life is stressful? _____.

Describe your energy level ☐ High (time of day) _____ ☐ Low (time of day) _____.

When do you usually go to bed? _____ How many hours do you sleep? _____.

☐ Hard to fall asleep ☐ Trouble staying asleep ☐ Wake too early ☐ Excess dreaming ☐ Restful

General:

☐ Loss of Appetite ☐ Excessive Appetite ☐ Recent weight loss ☐ Recent weight gain
☐ Odd taste in mouth ☐ Fatigue ☐ Get sick often ☐ Fever ☐ Dizziness ☐ Bruise easily

☐ Rarely sweat ☐ Sweat a lot ☐ Night sweats ☐ Easily overheated ☐ Crave cold drinks
☐ Often feel cold ☐ Crave hot drinks ☐ Cold hands & feet ☐ Food cravings _____.

Head, Eyes, Ears, Nose, Throat:

☐ Dry eyes	☐ Toothaches	☐ Dry mouth	☐ Sinus congestion
☐ Eye strain	☐ Gum problems	☐ Sore throat	☐ Post nasal drip
☐ Blurry vision	☐ TMJ	☐ Ringing in the ears	☐ Nose bleeds
☐ Floaters	☐ Mouth sores	☐ Hearing loss	☐ Loss of smell
☐ Wear contacts	☐ Difficulty swallowing	☐ Earaches	☐ Migraines ☐ with aura

☐ Headaches - Where is the pain? _____.

Triggered by light, smells, hunger? _____.

Skin & Hair:

☐ Dry skin ☐ Itching ☐ Oily skin ☐ Acne - where?_____.
☐ Rashes ☐ Hives ☐ Eczema ☐ Fungal infections ☐ Hair loss ☐ Dry scalp ☐ Weak nails

Chest/Heart:

☐ Difficulty breathing ☐ Shortness of breath ☐ Wheezing ☐ Cough ☐ Chest tightness
☐ Pain in chest ☐ Palpitations ☐ Coughing blood ☐ Coughing phlegm - color _____.
☐ Irregular heartbeat ☐ Rapid heartbeat ☐ Varicose veins ☐ Poor circulation

Digestion:

☐ Nausea ☐ Gas ☐ Burping ☐ Acid reflux ☐ Hiccups ☐ Rectal pain
☐ Vomiting ☐ Bloating ☐ Bad breath ☐ Abdominal pain ☐ Hemorrhoids
Bowel movements are: ☐ regular ☐ difficult ☐ soft ☐ loose ☐ small pellets ☐ long, thin
with: ☐ blood ☐ mucus ☐ cramping ☐ urgency ☐ undigested food
How many bowel movements do you have a day? _____.

Urination :

☐ frequent ☐ difficult ☐ painful ☐ incomplete ☐ scanty ☐ urgent ☐ wake to urinate
☐ burning ☐ cloudy ☐ bloody ☐ leaking ☐ frequent urinary infections
How many times a day do you urinate? _____.

Musculoskeletal:

Pain in ☐ Neck ☐ Upper Back ☐ Shoulder ☐ Arm ☐ Elbow ☐ Wrist ☐ Hand
☐ Jaw ☐ Face ☐ Low Back ☐ Ribs ☐ Hip ☐ Leg ☐ Knee ☐ Ankle ☐ Foot
☐ Joint pain ☐ Swollen Joints ☐ General Muscle aches ☐ Heavy limbs ☐ Muscle weakness
☐ Muscle tension ☐ Limited range of motion ☐ Muscle cramps ☐ Restless legs

Neuropsychological:

☐ Difficulty concentrating ☐ Poor Memory ☐ Depression ☐ Seasonal Affective Disorder - SAD
☐ Irritability ☐ Nervousness ☐ Worry a lot ☐ Anxiety ☐ Panic Attacks ☐ Mania/Depression
☐ Quick to anger ☐ Obsessive thoughts ☐ Numbness ☐ Tics ☐ Tremors

Uro-genital/Reproduction: Do you wake with a morning erection? _____.

☐ Injuries to genitals ☐ Nocturnal emission ☐ Premature ejaculation ☐ Fatigue after ejaculation
☐ Difficulty in obtaining an erection ☐ Change in sex drive ☐ Difficulty in maintaining an erection
☐ Prostate infection ☐ Enlarged Prostate ☐ Discharge from penis ☐ Herpes ☐ Other STDs
☐ Testicular pain ☐ Testicular lump ☐ Varicocele ☐ Late descending testicle ☐ Priapism

Fertility:

How long have you been trying to conceive with your partner?_____.

Have either of you had children with another partner? _____.

Have they had a fertility workup? ☐ no ☐ yes With whom? _____.

☐ Hormone panel (FSH, LH, Estradiol, Progesterone, Testosterone, AMH) ☐ Prolactin

☐ Ultrasound to evaluate lining, follicles ☐ HSG to evaluate fallopian tubes ☐ Endometrial biopsy

Have you had a fertility workup? ☐ no ☐ yes With whom? _____.

Did they check for ☐ Antisperm antibodies ☐ DNA fragmentation

Have you had a semen analysis? ☐ no ☐ yes Please give results or bring lab report with you:

Sperm count	mil	Motility	%	Morphology	%	WBCs	
Volume	mL	DNA fragmentation	%	Anti-Sperm Antibodies		pH	

Did either of you have:

☐ Autoimmune panel ☐ Thyroid panel ☐ Testing for blood clotting factors ☐ Genetic testing

Was there an infertility diagnosis? _____.

Are you more than 20% over or under your ideal body weight?_____.

Have you been exposed to any known environmental toxins or hormones? _____.

_____.

Are you taking any of the following medications? ☐ antibiotics ☐ antidepressants
☐ antihistamines ☐ NSAIDS (Advil, etc) ☐ blood pressure drugs ☐ cough medicine
☐ decongestants ☐ diuretics ☐ sleeping pills ☐ steroids ☐ chemotherapy drugs
☐ ulcerative colitis drugs ☐ antifungals ☐ Macrobid ☐ epileptic drugs ☐ peptic ulcer drugs
☐ migraine drugs ☐ painkillers ☐ Clomid ☐ testosterone ☐ Propecia (finasteride)

History of Fertility Treatment:

Please list below all IUI or IVF procedures. Include cycles that didn't go to transfer:

Treatment	When	Fresh, frozen, w/donor egg	ICSI or PGT	Name of Doctor	Result

Did you have any side effects from taking fertility medications? _____.

Is there anything else you'd like to discuss? _____.

Thank you for taking the time to fill out this very detailed information so that I can have a complete understanding of your past and current health. I look forward to working with you!

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