



HEALTH HISTORY for MEN



Please mark an X on the scales and check any boxes of symptoms you have had in the past month

TEMPERATURE

How warm / cold you feel (not in degrees); relative to other people do you wear more or less layers, etc.

COLD

HOT

- Cold hands or feet
- Chills
- Cold "in the bones"
- Areas of numbness

- Thirst for cold / hot drinks
- Thirst, no desire to drink
- Absence of thirst
- Excessive thirst

- Night sweats
- Unusual sweats
- When _____ am / pm
- Where on body _____

- Hot hands, feet, chest
- Hot flashes
- Hot in afternoon
- Hot at night

MOISTURE

Your overall body moisture (hair, skin, mouth, bowels, etc.)

DRY

OILY

- Dry skin
- Dry hair
- Dry eyes
- Dry brittle nails

- Dry mouth
- Dry lips
- Dry throat
- Dry nose / Nosebleeds

- Where on your body?:
- Edema / Swelling _____
 - Rashes _____
 - Itching _____
 - Dandruff

- Oily skin
- Oily hair
- Pimples
- Weight gain / loss

DIGESTION

DIARRHEA

CONSTIPATION

- BM: How often? _____ x / every _____ days
- Stools keep shape? Y N
- Alternating diarrhea & constipation (IBS)
 - Indigestion

- Gas
- Bloating
- Belching
- Poor appetite

- Nausea / Vomiting
- Bad breath
- Heartburn
- Excessive hunger

- Dry Stools
- Difficult to pass
- Tired after BM
- Foul smelling stools

ENERGY

LOW

HIGH

- Sudden energy drop
- Time of day: _____ am / pm
- Energy drop after eating
- Fatigue

- Dependence on caffeine / stimulants
- Wired / ungrounded feeling
- Body / Limbs feel heavy
- Body / Limbs feel weak

- Shortness of breath
- Heart Palpitations
- Blood pressure High / Low
- Bleed / Bruise easy

- Hard to concentrate
- Poor memory
- Dizziness / lightheaded
- Headaches _____ x / week

SLEEP

- # hours per night _____
- Difficulty falling asleep
 - Wake _____ x / night @ _____ am / pm
 - Wake to urinate How often? _____
 - Disturbing dreams
 - Restless sleep
 - Not rested upon waking

EMOTIONS

What emotion(s) dominate your experience?

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Grief |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Joy |
| <input type="checkbox"/> Worry | <input type="checkbox"/> Fear |
| <input type="checkbox"/> Obsessive thinking | <input type="checkbox"/> Timid / shy |
| <input type="checkbox"/> Sadness | <input type="checkbox"/> Indecision |

EYES, EARS NOSE THROAT

- | | |
|---|--|
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Poor hearing |
| <input type="checkbox"/> Night blindness | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Red eyes | <input type="checkbox"/> Excess earwax |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Dental problems |
| <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Mouth sores |
| <input type="checkbox"/> Phlegm (color _____) | <input type="checkbox"/> Cough |

URINARY

- Fluid in = fluid out? Y N
- Decrease in flow
 - Dribbling
 - Difficulty starting / stopping
 - Incontinence
 - Kidney stones
 - Urgency to urinate
 - Frequent urination
 - Pain on urination
 - Burning sensation
 - Cloudy urine
 - Blood in urine

REPRODUCTIVE

- Are you sexually active? Y N
- Change in Sex Drive? Y N
- Erectile dysfunction
 - Sores on genitals
 - Discharge
 - Premature ejaculation
 - Prostate disease
 - Genital Pain
 - Jock Itch
 - Vasectomy
 - Hernia
 - Hemorrhoids