# APEX ADVANCED HEALTH SOLUTIONS

**JIM SMITH, D.O.**
**FUNCTIONAL MEDICINE**

**RONNIE ROBERTSON III**
**HEALTH & LIFESTYLE**

**https://www.apexadvancedhealthsolutions.com — Ph: 513.942.3226 — Fx: 513.942.3934**

# Male Extensive Medical and Health Survey

| | | | | | |
|---|---|---|---|---|---|
| Name: | Age: | Sex: | Marital status: M S D W | Birth date: | |
| Address: | City: | | St: | Zip: | |
| Phones: Home | Work: | Fax: | Cell: | | |
| Occupation: | Past occupations: | | | | |
| Name of spouse/partner: | Age: | Occupation: | | | |
| Best days & times to reach you: | E-mail: | | | | |
| How did you hear about us? | Travel time to office: | | | | |
| **Credit Card info, if indicated:** Card holder name: | Credit Card type: MC VISA DIS | | | | |
| Credit Card #: | Exp. date: | V-Code (3 digits on back of card): | | | |
| Credit Card billing address: | | | | | |

**PLEASE DESCRIBE YOUR MAJOR PROBLEMS AND/OR SYMPTOMS.** If none, please write your reason for seeking this consultation. Please be clear and concise to help us help you. Include when the symptoms first appeared. Write what you can in the space provided. If you need more space add a separate sheet of paper.

If you have seen other physicians for these problems, indicate the results of these evaluations:

List your short-term goals for coming to this office:

List your long-term goals:

| | | | | |
|---|---|---|---|---|
| Height: | Weight: | Lowest adult wt: | Highest adult wt: | Desired wt: |
| Last Dr. visit: | Blood pressure: | Heart rate: | Allergies/sensitivities list: | |

| | | | | |
|---|---|---|---|---|
| Smoke | Y N | Year started: | Packs per day: | Year stopped: |
| Alcohol | Y N | Year started: | How much: | Year stopped: |
| Street drugs | Y N | Type: | How often: | Year stopped: |
| Caffeine | Y N | Type: | How much: | How much: |
| Sleep problems | Y N | Type: | Type: | Type: |
| Exercise | Y N | Type: | How Often: | How often: |
| Cosmetics Y N | Perfumes Y N | Aftershaves Y N | Scented soaps Y N | |

**Do you have now or have you ever had any problems with any of the following?**

| | | | | | |
|---|---|---|---|---|---|
| 1 | HEAD, NECK | Y N | 13 | PENIS, TESTICLES | Y N |
| 2 | EYES, VISION | Y N | 14 | BACK, SHOULDER BLADES | Y N |
| 3 | EARS, HEARING | Y N | 15 | RIBS, HIPS | Y N |
| 4 | TEETH | Y N | 16 | ARMS, LEGS | Y N |
| 5 | NOSE, MOUTH, VOICE | Y N | 17 | NERVE, BRAIN DISEASE | Y N |
| 6 | LUNGS, BREAST, CHEST | Y N | 18 | SEIZURE, MIGRAINES | Y N |
| 7 | HEART | Y N | 19 | SKIN PROBLEMS | Y N |
| 8 | ARTERIES, VEINS | Y N | 20 | BLOOD DISEASES, SPLEEN | Y N |
| 9 | STOMACH, GALLBLADDER | Y N | 21 | GLANDS, OBESITY | Y N |
| 10 | LIVER, PANCREAS | Y N | 22 | CANCER | Y N |
| 11 | BOWELS, RECTUM, HERNIA | Y N | 23 | PSYCHIATRIC PROBLEMS | Y N |
| 12 | KIDNEY, BLADDER | Y N | 24 | OTHER CONDITIONS | Y N |

**Explain Any "Yes" Answers:**

**Major Hospitalizations-List:**

**Heart Disease Risk Factors**

| | |
|---|---|
| Y N | Age Years - Male ≥ 45<br>Female ≥ 55 or early menopause without estrogen replacement therapy |
| Y N | Family history of premature Heart Disease (definite myocardial infarction or sudden death before 55 in father / close male relative, or 65 in mother / close female relative) |
| Y N | Current cigarette smoker |
| Y N | Hypertension (Blood pressure ≥ 140/90 mm Hg confirmed by measurements on several occasions or taking antihypertensive medication |
| Y N | Low HDL (good) cholesterol (<35 mg/dl confirmed by measurements on several occasions [0.9 mmo/L] |
| Y N | Diabetes mellitus (sugar) |
| Y N | High HDL (good) cholesterol (≥ 60 mg/dl [1.6 mmo/L] |

| | | | | |
|---|---|---|---|---|
| **Your Tests, Specify if known:** | | Last Physical: | Xrays: | GI Series: |
| Gall bladder: | Kidney: | EKG: | Stress EKG: | Angiogram: |
| Ultrasound: | Blood Tests: | Others: | | |



**Name:** _____

**Name:** _____

Have you ever been on prolonged antibiotic therapy: Y N If Yes, what & why:

Have you traveled out of the country? Y N If yes, where & when?

Have you been treated for parasites? Y N Have you been tested for parasites? Y N

Do you do any stress reduction/relaxation such as meditation, yoga, self-hypnosis, etc.? Y N

| What: | How Often: | Length of Sessions: | |
|---|---|---|---|
| Your stress level: Low Moderate High | | | |
| Sleeping Habits: | Hours/Night: | Restless or Restful | What Time You Retire: |
| | Wake During Night: Y N | Dream: Y N | |

What are your hobbies or interests?

**Immunizations, if Known:**

| Smallpox: | Polio: | Mumps: | Pneumonia: | Pertussis: |
|---|---|---|---|---|
| Tetanus: | Flu: | Measles: | Diphtheria: | Other: |

Did your mother have any problems during her pregnancy with you (illness, stress, smoking, meds, alcohol)? Y N

Were you bottle or breast fed? Was your home life (circle): loving supportive stressful abusive peaceful

loud argumentative educational alcoholic friendly single-parent lonely or other—list

Childhood Illnesses (circle): colic eczema asthma polio allergies bronchitis pneumonia meningitis rheumatic fever recurrent colds

ear infections thrush German measles bedwetting tonsils out persistent diaper rash learning problems hyperactive or others—list

| Family History | Living | Age | Health Problems**, Mental Illnesses or Cause of Death |
|---|---|---|---|
| Father | Y N | | |
| Mother | Y N | | |
| Brothers/Sisters | # | | |
| Children | # | | |

** Cancer, Thyroid, Hypertension, Heart Disease, Stroke, Diabetes, Aortic Aneurysm, Asthma

**Other household members now living with you. Include family members, non-family members and pets.**

| Name | Relationship | Age | Occupation |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Please indicate if you or any family members or grandparents, ever had any of the following problems—Specify**

| | |
|---|---|
| Alcoholism | Allergies |
| Arthritis | Asthma |
| Cancer | Epilepsy |
| Colitis/Crohn's Ds. | Diabetes |
| Herpes | Shingles |
| Drug Problems | Eczema |
| Heart Disease | High Blood Pressure |

**Please indicate if you or any family members or grandparents, ever had any of the following problems—Specify**

| | |
|---|---|
| Hepatitis | Frequent Infections |
| High Cholesterol | Bleeding/Bruising |
| Anemia | Low Blood Sugar |
| Digestive Disease | Weight Problems |
| Psoriasis | Urinary infections |
| Lupus | Mental Illness |
| Migranes | Pneumonia |
| Polio | Prostate Problems |
| Rheumatic Fever | Rheumatoid Disease |
| Sinus Disease | Strokes |
| Thyroid Problems | Tuberculosis |
| Ulcers | Venereal Disease |

Comments/Explanations

**Read carefully through the list of symptoms in each group, and put a check mark next to each symptom that you have. (If you check off the same symptom in more than one group, that's fine.)**

| **Symptom Group 1** | | **Symptom Group 2** | | **Symptom Group 6** | |
|---|---|---|---|---|---|
| Weight loss | | Hair loss | | Debilitating fatigue | |
| Loss of muscle | | Prostate enlargement | | Low blood pressure | |
| Lower sex drive | | Irritability | | Intolerance to exercise | |
| Fatigue | | Puffiness/bloating | | Unstable blood sugar | |
| Enlarged breast | | Headaches | | Thin and/or dry skin | |
| Lower stamina | | Breast enlargement | | Foggy thinking | |
| Softer erections | | Weight gain | | Brown spots on face | |
| Gallbladder problems | | | | | |
| ***TOTAL BOXES CHECKED*** | | ***TOTAL BOXES CHECKED*** | | ***TOTAL BOXES CHECKED*** | |

Date of last prostate exam: Was it normal? Y N If no, explain:

Date of last PSA? What was the value?

Date last stools checked for blood: Was it normal? Y N If no, explain:

Date of last sigmoidoscopy or colonoscopy? Was it normal? Y N If no, explain:

**Living Environment—circle:** Urban Suburban Country Seaside Lakeside

Type of Heat: Humidifier: Y N Wood Stove: Y N Type of Insulation:

Is the Cellar: Dry Damp Musty Dusty Is the House: Old New Has it been treated for pests? Y N What Kind?

Do you use feather or down covers, comforters or jackets? Y N Do you have an air filter or cleaner? Y N

Are there animals at home or places you visit frequently? Y N What kind:

Do you use strong chemical cleaners, solvents, paints, etc.? Y N What?

**Notes:**



**Name:** _____

**Name:** _____

**Fill in "C" for current problem; "I" for an intermittent problem; "P" for a past problem**

| | | |
|---|---|---|
| ___ Headaches | ___ High blood pressure | ___ Weakness |
| ___ Neck lumps or swelling | ___ Skipped heartbeats | ___ Painful feet |
| ___ Loss of balance | ___ Racing heart | ___ Leg cramps |
| ___ Dizzy spells | ___ Chest pain or pressure | ___ Trembling or tremors |
| ___ Vertigo | ___ Swollen feet or ankles | ___ Seizures or epilepsy |
| ___ Blackouts or fainting | ___ Difficulty breathing at night | ___ Numbness or tingling |
| ___ Blurry vision | ___ Varicose veins or phlebitis | ___ Skin tumors |
| ___ Double vision | ___ Recurring indigestion | ___ Dry skin |
| ___ Cataracts | ___ Nausea or vomiting | ___ Acne |
| ___ Eye pain or itching | ___ Intestinal gas/ flatulence | ___ Eczema |
| ___ Watering eyes or redness | ___ Belching | ___ Skin rashes |
| ___ Hearing difficulties | ___ Bloating | ___ Psoriasis |
| ___ Earaches or drainage | ___ Abdominal pain or cramps | ___ Dandruff or seborrhea |
| ___ Noises or ringing in ears | ___ Constipation | ___ Hives |
| ___ Recurrent ear infections | ___ Diarrhea or loose stools | ___ Itching or burning skin |
| ___ Dental problems/ decay | ___ Rectal itching | ___ Easy bruising |
| ___ Sore or bleeding gums | ___ Blood with stools | ___ Hypothyroid (low) |
| ___ Sore tongue | ___ Black stools | ___ Hyperthyroid (high) |
| ___ Coated tongue | ___ Pain in rectum | ___ Weight gain |
| ___ Loss of taste or smell | ___ Jaundice | ___ Weight loss |
| ___ Sores in or around mouth | ___ Hepatitis/pancreatitis | ___ Feel excessively warm |
| ___ Difficulty swallowing | ___ Colitis | ___ Feel excessively cold |
| ___ Cold sores or blisters | ___ Crohn's disease | ___ Loss of appetite |
| ___ Sinus or nasal congestion | ___ Diverticulitis/diverticulosis | ___ Constant hunger |
| ___ Runny nose | ___ Frequent urination | ___ Fatigue or weariness |
| ___ Frequent colds | ___ Brown or red urine | ___ Night sweats |
| ___ Nasal polyps | ___ Decreased force of urine | ___ Diabetes |
| ___ Sore throats | ___ Continual urge to urinate | ___ Low blood pressure |
| ___ Swollen glands | ___ Difficulty starting urination | ___ Nervousness or anxiety |
| ___ Recurrent fevers or chills | ___ Kidney or bladder infection | ___ Depression |
| ___ Hoarse voice | ___ Involuntary escape of urine | ___ Suicidal thoughts |
| ___ Shortness of breath | ___ Venereal disease | ___ Sought psychological help |
| ___ Wheezing or gasping | ___ Aching muscles or joints | ___ -MEN ONLY- |
| ___ Coughing | ___ arthritis | ___ Painful testicles |
| ___ Coughing blood | ___ Joint stiffness | ___ Hernia |
| ___ Chest colds or pneumonia | ___ Back or neck pain | ___ Prostate problems |
| ___ Heart murmur | ___ Osteoporosis | ___ Sexual dysfunction |

**Fill in the number that best describes your feelings most recently.**

**0 = not at all; 1 = a little bit; 2 = moderately; 3 = quite a bit; 4 = extremely**

___ Nervousness or shakiness inside
___ Repeated unpleasant thoughts
___ Loss of sexual interest or pressure
___ Feeling exuberant or enthusiastic
___ The idea that others can control your thoughts
___ Feeling others are to blame for your troubles
___ Trouble remembering things
___ Feeling afraid in open spaces or outside
___ Feeling critical of others
___ Feeling that your goals and aims are clear in life
___ Thoughts of ending your life
___ Hearing voices that others do not hear
___ Feeling easily annoyed or irritated
___ Crying easily
___ Feeling happy and lighthearted
___ Feeling shy or uneasy with the opposite sex
___ Feeling of being trapped or caught
___ Temper outbursts that you cannot control
___ Blaming yourself for things
___ Feeling blocked in getting things done
___ Feeling in control of your life
___ Feeling lonely
___ Feeling blue or depressed
___ Facing daily tasks is a source of pleasure
___ Worrying too much about things
___ Feeling no interest in things
___ Feeling fearful or afraid
___ Your feelings are hurt easily
___ Others are aware of your private thoughts
___ Others do not understand you
___ Must do things very slowly to insure correctness
___ Feeling watched or talked about by others
___ Difficulty making decisions

___ Your mind is in a fog
___ Having a lump in your throat
___ Feeling tense or keyed up
___ Heavy feeling in your arms or legs
___ Thoughts of death or dying
___ Feeling uneasy when people are watching you
___ Having to repeat the same actions over and over
___ Having urges to break or smash things
___ Feeling self-conscious with others
___ Having a good sense of humor
___ Feeling everything is an effort
___ Spells of panic or terror
___ Getting into frequent arguments
___ Feeling relaxed
___ Felling nervous when you are left alone
___ Feeling that others do not give you proper credit for your achievements
___ Feeling your life is filled with good things
___ Feeling lonely even when you are with people
___ Never feeling close to another person
___ Feeling at peace with your surroundings
___ Feelings of guilt
___ Having the idea that something is wrong with your mind
___ Feeling very responsible for others
___ Feeling able to turn to your family for help when something is troubling you
___ Feeling satisfied with your family's affection and responses to your emotional needs
___ Feeling harmony in your personal world
___ Feeling angry
___ Feeling that your ability to find meaning in life is very great
___ Being a responsible person
___ Feeling good about your personal relationships
___ Feeling afraid to travel by bus, train, or in cars
___ Feeling your personal existence is valuable



**Name:** _____

**Name:** _____

**This index indicates degrees of stress related to changes in life. In studies, many people who scored over 300 became ill within a 3 to 6 month period. If an event has been true for you in the past year, or is about to happen, circle the associated point value. If an unlisted event has occurred, add it to the bottom of the list and assign it a point value. Add up the points.**

| | |
|---|---|
| Death of spouse or partner | 100 |
| Divorce | 73 |
| Separation from spouse or partner | 65 |
| Jail term | 63 |
| Death of a close family member | 63 |
| Personal injury or illness | 53 |
| Marriage/commitment to a partner | 50 |
| Fired at work | 47 |
| Reconciliation with a spouse/partner | 45 |
| Retirement | 45 |
| Change in health of family member | 44 |
| Pregnancy | 40 |
| Sex difficulties | 39 |
| Addition of new family member | 39 |
| Business readjustment | 39 |
| Change in financial state | 38 |
| Death of a close friend | 37 |
| Change to a different line of work | 36 |
| More arguments with spouse/partner | 35 |
| Mortgage over 50,000 | 31 |
| Foreclosure of mortgage or loan | 30 |
| Change in work responsibilities | 29 |
| Child leaving home | 29 |
| Trouble with in-laws | 29 |
| Outstanding personal achievements | 28 |
| Spouse/partner begins/stops work | 26 |
| Begin or end school | 26 |
| Change in living conditions | 25 |
| Revision of personal habits | 24 |
| Trouble with boss or employee | 23 |
| Change in work hours or conditions | 20 |
| Change in residence | 20 |
| Change in schools | 20 |
| Change in recreation | 19 |
| Change in church activities | 19 |
| Change in social activities | 18 |
| Mortgage or loan under 50,000 | 17 |
| Change in sleeping habits | 16 |
| Change in eating habits | 15 |
| Vacation | 13 |
| Christmas approaching | 12 |
| Minor violations of the law | 11 |
| Other | |
| Other | |
| **TOTAL OF ALL POINTS** | |

**Specify what foods and beverages you normally consume during a typical day.**

**Weekdays**

Breakfast

Snack

Lunch

Snack

Dinner

Snack

**Weekends**

Breakfast

Snack

Lunch

Snack

Dinner

Snack

Do you binge? Y N Use foods for reward or escape? Y N

If so, what foods or beverages do you use, and how often?

What foods would be most difficult to give up?

Do you have specific food cravings? Y N What Foods?

What work or scheduling considerations might create difficulties for you trying to change your eating or any other health habits?

List any known food allergies:

**Please check the following boxes according to the frequency of your personal habits.**

***Frequent*** **= at least once per day;** ***Often*** **= several times per week;** ***Occasional*** **= once per week or less;**
***Seldom*** **= once or twice per month or less;** ***Never*** **= almost total avoidance**

| Frequent | Often | Occasional | Seldom | Never | |
|---|---|---|---|---|---|
| | | | | | 1. Alcoholic beverages |
| | | | | | 2. Eat at restaurants |
| | | | | | 3. Eat at fast food restaurants |
| | | | | | 4. Pastries, cookies, candies, ice cream, other sweets |
| | | | | | 5. Add sugar to coffee, tea, cereals or other foods |
| | | | | | 6. Colas or other soft drinks |
| | | | | | 7. Instant breakfasts, pop tarts, doughnuts, muffins |
| | | | | | 8. Cold breakfast cereals |
| | | | | | 9. Caffeine drinks ( coffee, tea, cola, chocolate) |
| | | | | | 10. Deep fried foods |
| | | | | | 11. Margarine of any type |
| | | | | | 12. Whole grain hot cereals ( oatmeal, wheatena, etc.) |
| | | | | | 13. Meat ( beef or veal, pork or ham, liver ,lamb) |
| | | | | | 14. Chicken or turkey -circle : regular or free range |
| | | | | | 15. Fresh fish |
| | | | | | 16. Processed meat ( bologna, turkey roll, sausage, etc.) |
| | | | | | 17. Fresh raw fruit |
| | | | | | 18. Fresh vegetables, raw or cooked |
| | | | | | 19. Salads |
| | | | | | 20. Whole grains or whole grain breads |
| | | | | | 21. White bread or white flour products |
| | | | | | 22. Beans and legumes (lentil, kidney, chickpea, etc.) |
| | | | | | 23. Yogurt– circle: whole or low-fat, plain or flavored |
| | | | | | 24. Milk– circle: whole or low- fat or skimmed |
| | | | | | 25. Cheese |
| | | | | | 26. Eggs– circle: regular or free range |
| | | | | | 27. Salt |
| | | | | | 28. Herbs, fresh and dried, or spices |
| | | | | | 29. Drink adequate water—circle: tap, filtered, or bottled |
| | | | | | 30. Eat excessively if bored or depressed |
| | | | | | 31. Swallow food before chewing well |
| | | | | | 32. Hurried or rushed meals |
| | | | | | 33. Stuff yourself |
| | | | | | 34. Read and understand food labels |
| | | | | | 35. Sneak or hide foods |
| | | | | | 36. Adequate fiber or roughage in the diet |
| | | | | | 37. Artificial sweeteners (saccharin, Nutrasweet, etc.) |
| | | | | | 38. Shop at health food stores |



**Name:** _____

# DO NOT PASTE OR ATTACH LABELS

| INGREDIENT | AMOUNT IN MULTIPLE VITAMIN-MINERAL | AMOUNT IN INDIVIDUAL SUPPLEMENTS | DAILY TOTAL |
|---|---|---|---|
| Vitamin A | | | |
| Beta-Carotene | | | |
| Vitamin B1 (Thiamine) | | | |
| Vitamin B2 (Riboflavin) | | | |
| Vitamin B3 (Niacin) | | | |
| Vitamin B3 (Niacinamide) | | | |
| Vitamin B5 (Pantothenic Acid) | | | |
| Vitamin B6 (Pyridoxine) | | | |
| Vitamin B12 (Cobalmin) | | | |
| Vitamin C | | | |
| Vitamin D | | | |
| Vitamin E | | | |
| Vitamin K | | | |
| Biotin | | | |
| Folic Acid | | | |
| Choline | | | |
| Inositol | | | |
| Bioflavonoids | | | |
| Boron | | | |
| Calcium | | | |
| Chromium | | | |
| Copper | | | |
| Iodine | | | |
| Iron | | | |
| Magnesium | | | |
| Manganese | | | |
| Molybdenum | | | |
| Phosphorus | | | |
| Potassium | | | |
| Selenium | | | |
| Silica | | | |
| Zinc | | | |



Name: _____

| INGREDIENTS (Herbals, etc) | AMOUNT IN SINGLES | AMOUNT IN BLENDS | DAILY TOTAL |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| MEDICATIONS | DOSE | DIRECTIONS | FOR WHAT? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**If you need more space add a separate sheet of paper.**



**Name:** _____