DR. JIM'S SHOTS FOR HEALTH

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Male Medical and Health Survey

Accurate completion of this form will assure that you receive the best possible consultation

Name: Age: E-mail:

Address: City: St: Zip:

Home Phone: Cell Phone: Marital Status: Birthdate:

Occupation: Best Days and Times to Reach You:

How Did You Hear About Us-Please Be Specific:

Height: Weight: Blood Pressure: Heart Rate:

List Illnesses and Dates:

List Surgeries, Hospitalizations and Dates:

All Allergies:

Personal Physician Name and Address & Phone#:

Please describe you 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.

HEART DISEASE RISK FACTORS

Y	N	Age Years - Male ≥ 45 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]

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

REVIEW OF SYSTEMS:

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

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

EXPLAIN any YES answers:

SMOKE	Y N	HOW LONG:	PACKS PER DAY:
ALCOHOL	Y N	HOW LONG:	HOW MUCH:
STREET DRUGS	Y N	TYPE:	HOW OFTEN:
CAFFEINE BEVERAGES	Y N	TYPE:	QUANTITY:
SLEEP PROBLEMS	Y N	TYPE:	
EXERCISE REGULAR	Y N	TYPE:	HOW OFTEN:

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

Weight loss_____
Loss of muscle_____
Lower sex drive_____
Fatigue_____
Enlarged breast_____
Lower stamina_____
Softer erections_____
Gallbladder problems_____

TOTAL BOXES CHECKED_____

Symptom Group 2

Hair loss_____
Prostate enlargement_____
Irritability_____
Puffiness/bloating_____
Headaches_____
Breast enlargement_____
Weight gain_____

TOTAL BOXES CHECKED_____

Symptom Group 6

Debilitating fatigue_____
Low blood pressure_____
Intolerance to exercise_____
Unstable blood sugar_____
Thin and/or dry skin_____
Foggy thinking_____
Brown spots on face_____

Date of last prostate exam? _____ Was it normal?_____

If no, explain._____

Date of last PSA? _____ What was the value? _____

Date stools last checked for blood?_____ Was it normal?_____

If no, explain._____

Date of last sigmoidoscopy or colonoscopy?_____ Was it normal?_____

If no, explain._____

Please attach a list of all Prescription Medications and Over-the-Counter Medications you are taking .

Use this space for extra comments.