



The Center For Healthy Living & Longevity

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Adult Male Questionnaire

Today's Date: ___/___/___ BLOOD TYPE: _____

Patient Name: _____ Birth date: ___/___/___ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cellular _____ Work: _____

Email: _____

Type of Health Insurance: PPO ___ HMO ___ Other _____

Occupation: _____ Social Security # _____

Previous Occupations: _____

Single ___ Married ___ Widowed ___ Divorced ___

Height: _____ Weight: _____

- Do you use tobacco? ___ Yes How much per day? _____ No
- Do you use alcohol? ___ Yes How much per day? _____ No
- Do you use caffeine? ___ Yes How much per day? _____ No
- Tea, Coffee or Chocolate? _____
- **Do you use artificial sweeteners?** ___ Yes What type? _____ No
- Do you drink carbonated beverages? ___ Yes How many per day? _____ No
- Do you have any pets? ___ Yes Type? _____ No
- Have you lived or traveled outside of the United States?
If so, when and where? _____

Allergies: Please check all that apply

___ Penicillin ___ morphine ___ dye allergies ___ seasonal (pollen) allergies

___ Codeine ___ aspirin ___ nitrate allergy ___ no known allergies

___ sulfa drugs ___ food allergies ___ pet allergies ___ other: _____

Please describe the allergic reaction you experienced and when it occurred: _____

Over-the-counter (OTC) issues: Please check all products that you used occasionally or regularly.

___ pain reliever ___ combination products (cough & cold reliever, Triaminic DM®)

___ aspirin ___ sleep aids (Excedrin PC®, Unisom®, Sominex®, Nytol®)

___ acetaminophen (Tylenol®) ___ anti-diarrheals (Imodium®, Pepto Bismol®, Kaopectate®)

___ ibuprofen (Motrin IB®) ___ Laxatives / stool softener (Doxidan®, Correctol®)

___ naproxen (Aleve®) ___ Diet aids / weight loss products (Dexatrim®)

___ ketoprofen (Orudis KT®) ___ antacids (Maalox®, Mylanta®)

___ cough suppressant (Robitussin DM®) ___ acid blockers (Tagamet HB®, Pepcid C®, Zantac 75®)

___ antihistamine (Benadryl, Chlor-Trimeton®) ___ others: _____

___ decongestant (Sudafed®)

Vitamin/Mineral Supplements You Are Taking	Date Started	Dosage

Describe your eating habits including the times you usually eat: (include deserts)

Breakfast	Lunch	Dinner	Type of Snacks

What foods to you crave?

Medical Conditions / Diseases: Please check all that apply to you.

- | | |
|---|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Blood clotting problems |
| <input type="checkbox"/> High cholesterol or lipids (e.g. hyperlipidemia) | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High blood pressure (e.g. hypertension) | <input type="checkbox"/> Arthritis or joint problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Ulcers (e.g. stomach, esophagus) | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Headaches/migraines |
| <input type="checkbox"/> Hormonal related issues | <input type="checkbox"/> Eye disease (e.g. glaucoma, etc.) |
| <input type="checkbox"/> Lung conditions (e.g. asthma, emphysema, COPD) | <input type="checkbox"/> Thyroid disease - goiter, nodules, low thyroid |

Other:

Please describe any past medical history:

Past Surgeries:

Current Prescription Medications:

Medication Name	Reason for Taking?	Strength	Date Started
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How often have you taken antibiotics?

Hormones previously taken Date Started Date Stopped Reason

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Dental History

How many Silver/Mercury Amalgams do you have? _____

Recent cavities, crowns, root canals? Describe: _____

History of any Gum Disease? Describe: _____

Do you have a family history of any of the following?

Enlarged Prostate	_____ No	_____ Yes	Family member(s)	_____
Prostate Cancer	_____ No	_____ Yes	Family member(s)	_____
Other Cancers	_____ No	_____ Yes	Family member(s)	_____
Heart disease	_____ No	_____ Yes	Family member(s)	_____
Osteoporosis	_____ No	_____ Yes	Family member(s)	_____
Diabetes	_____ No	_____ Yes	Family member(s)	_____
Hypertension	_____ No	_____ Yes	Family member(s)	_____
Allergies/Asthma	_____ No	_____ Yes	Family member(s)	_____
Alzheimer's/Dementia	_____ No	_____ Yes	Family member(s)	_____
Eczema	_____ No	_____ Yes	Family member(s)	_____

Any other family history we should know about?

Lifestyle Questions

1. How often do you exercise? _____

2. During the past 12 months, how often have you felt excessive stress in your life?

Never _____ Occasionally _____ Often _____ Almost always _____

Have you experienced any major losses in life? Yes _____ No _____

If so, please comment:

3. How would you describe your health?

Excellent _____ Very good _____ Good _____ Fair _____ Poor _____

Please indicate your symptoms for the following conditions:

	ABSENT	MILD	MODERATE	SEVERE
Prostate problems	_____	_____	_____	_____
Weight Gain	_____	_____	_____	_____
Carbohydrate Craving	_____	_____	_____	_____
Chocolate Craving	_____	_____	_____	_____
Constipation	_____	_____	_____	_____
Dry Skin / Hair	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Night Sweats	_____	_____	_____	_____
Headaches/Migraines	_____	_____	_____	_____
Irritability	_____	_____	_____	_____
Mood Swings	_____	_____	_____	_____
Sleep Disturbances / Insomnia	_____	_____	_____	_____
Fluid Retention	_____	_____	_____	_____
Fatigue	_____	_____	_____	_____
Memory Loss	_____	_____	_____	_____
Incontinence/frequent urination	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Decreased libido	_____	_____	_____	_____
Hair Loss	_____	_____	_____	_____
Thyroid Goiter	_____	_____	_____	_____
Heartburn/Indigestion	_____	_____	_____	_____
Diarrhea	_____	_____	_____	_____
Gas/Bloating	_____	_____	_____	_____

Do you have any risk factors for blood clots? (circle ones below)

- **Cancer**
- **Prior blood clot (DVT)**
- **Advanced age**
- **Restricted mobility longer than 3 days**
- **Inherited clotting disorder**
- **Overweight**
- **Recent hospitalization**
- **Major surgery in previous 4 weeks**
- **Pregnancy or post partum**
- **Long plane or car trips (>4 hours) in previous 4 weeks**
- **Using birth control pills**
- **Take menopausal hormones by mouth**
- **Recent trauma**
- **Stroke**
- **Heart attack**
- **Heart Failure**
- **Nephrotic syndrome**
- **Ulcerative colitis**
- **Lower extremity fractures**
- **Systemic lupus erythematosus (SLE)**
- **Behçet syndrome**

ADAM Questionnaire

The ADAM questionnaire was developed by a physician and is used extensively by healthcare providers to help identify men who may have low testosterone.

1. Do you have a decrease in libido (sex drive)? Yes No
2. Do you have a lack of energy? Yes No
3. Do you have a decrease in strength and/or endurance? Yes No
4. Have you lost height? Yes No
5. Have you noticed a decreased "enjoyment of life?" Yes No
6. Are you sad and/or grumpy? Yes No
7. Are your erections less strong? Yes No
8. Have you noticed a recent deterioration in your ability to play sports? Yes No
9. Are you falling asleep after dinner? Yes No
10. Has there been a recent deterioration in your work performance? Yes No

Describe your problems that lead you to this consultation:

What are your goals with this consultation?

Please write down any specific questions you may have.

If possible, please fax or mail any recent lab work or other test results