

NAME

DATE

SOCIAL HISTORY:

Occupation and hours: _____ Stress Level 0 to 10 _____

Please circle:

Marital Status:	Single	Married	Separated	Divorced	Widowed
Use of alcohol:	Never	Occasionally	3-4 times /week	Daily	
Use of tobacco:	Never	Quit date _____	Current, packs/day _____		
Aerobic Exercise:	None	1-2X/week	3-4X/week	Daily	
Strength training:	None	1-2X/week	3-4X/week	Daily	
Meals/snacks/ day:	2	3-4 X/day	5-6X/day		
Vegetable intake:	<10%	20-40%	41-60%	>61%	

HOBBIES AND INTERESTS

FAMILY HISTORY (Please include *CANCER, STROKE, HIGH BLOOD PRESSURE, HEART ATTACKS, DIABETES, ALZHEIMER's, OSTEOPOROSIS, THYROID*):

	<i>AGE</i>	<i>DISEASES</i>	<i>If deceased: cause/age of death</i>
MOTHER	_____	_____	_____
Maternal GM	_____	_____	_____
Maternal GF	_____	_____	_____
FATHER	_____	_____	_____
Paternal GM	_____	_____	_____
Paternal GF	_____	_____	_____
AUNTS/UNCLES	_____	_____	_____
SIBLINGS	_____	_____	_____
CHILDREN	_____	_____	_____

SaJune Medical Center

NAME _____

DATE _____

Living children _____

Are you sexually active? _____ # times per week _____ Problems: _____

Circle if you are heterosexual, bisexual or homosexual

Are you in an abusive relationship? _____ Have you been sexually abused ? _____

Date of last PHYSICAL exam: _____ Past abnormalities: _____

Date of last PROSTATE exam: _____ Past abnormalities: _____

Date of last PSA: _____ Past abnormalities: _____

Date of last bone density screening: _____ Past abnormalities: _____

Please check all that apply

	NONE	MILD	MODERATE	SEVERE
Dry skin				
Dry Hair				
Sleep disorder				
Fatigue				
Memory loss				
Concentration loss				
Anxiety/ nervousness				
Irritability				
Depression				
Loss of libido/ orgasm				
Difficulty maintaining erection				
Difficulty achieving erection				
Premature ejaculation				
Muscle weakness				
Muscle Loss				
Muscle and Joint pain				
Loss of masculinity/confidence/aggressiveness				

NAME _____

DATE _____

REVIEW OF SYSTEMS		
Instructions: Please check YES to any symptom that you experience. For any YES answer please provide a brief description		
	YES	If YES, list doctor seen, describe condition and how long
General		
Have you seen an internist?		
Fever/chills		
Headache		
Dizziness		
Excess fatigue		
Insomnia		
Weight loss/gain		
Enlarged lymph nodes		
Frequent bruising		
Eyes/Ears/Nose/Mouth		
Have you seen ear, nose, throat doctor?		
Blurry vision		
Ringing in ears		
Difficulty with vision		
Difficulty with hearing		
Mouth sores		
Sinus problems		
Cardiovascular		
Have you seen a cardiologist?		
Chest pain at rest or exercise		
Shortness of breath		
Cold hands/ cold feet		
Swelling of legs		
Palpitations		
Gastrointestinal		
Have you seen a gastroenterologist?		
Constipation		# bowel movement /day _____
Diarrhea		
Bloating		
Excessive belching		
Gas/acidity		
Blood in stool		
Thirst: Lack of /too much		# glasses of fluid/day _____

NAME _____

DATE _____

REVIEW OF SYSTEMS		
Instructions: Please check YES to any symptom that you experience. For any YES answer please provide a brief description		
	YES	If YES, list doctor seen, describe condition and how long
Genitourinary		
Have you seen a urologist?		
Pain on urination		
Cloudy/bloody urination		
Urinating too many times		# times per day
Difficulty urinating		
Loss of urine		
Musculoskeletal		
Do you see a chiropractor?		
Do you get regular body treatment/ massage		
Back Pain		
Neck Pain		
Shoulder Pain		
Knee Pain		
Joint Pain		
Skin		
Do you see a skin care specialist?		
Acne		
Dry Skin		
Oily skin		
Loss of collagen/ firmness		
Wrinkles		
Pigmentation/Scarring		
Emotional		
Do you see counselor?		
Depression		
Anxiety		
Stress		
I have answered the above accurately to the best of my knowledge.		
XX Signature _____		