ADVANCED PAINCARE AND BIOHEALTH INSTITUTE

# Men's Wellness Questionnaire

| I. Patient Information | | | |
|---|---|---|---|
| Name: | | DOB: | Age: |
| Address: | | | |
| City: | State: | | Zip: |
| Phone: | Email: | | |
| Gender: | Height: | | Weight: |

| II. Goals |
|---|
| What are the top 3 symptoms/wellness goals you would like to address?<br><br>1.<br><br>2.<br><br>3. |

| IIII. Allergies: Circle any allergies below | | | |
|---|---|---|---|
| Penicillin | Morphine | Dye Allergies | Pet Allergies |
| Codeine | Aspirin | Nitrate Allergies | Seasonal(pollen) Allergies |
| Sulfa drug | Food Allergies | Unknow Allergies | Other:_____ |
| Describe the allergic reaction and when you experienced it_____ | | | |

| IV. Medical History | | |
|---|---|---|
| Check all that apply | Personal History | Family Member(s) |
| Heart Disease | Yes □ No □ | Yes □ No □ |
| High Blood Pressure | Yes □ No □ | Yes □ No □ |
| High Cholesterol | Yes □ No □ | Yes □ No □ |
| Thyroid Disease | Yes □ No □ | Yes □ No □ |
| Lung Conditions | Yes □ No □ | Yes □ No □ |
| Ulcers (GERD) | Yes □ No □ | Yes □ No □ |
| Prostate Cancer | Yes □ No □ | Yes □ No □ |
| Diabetes | Yes □ No □ | Yes □ No □ |
| Depression | Yes □ No □ | Yes □ No □ |

* Services offered including wellness visits, not covered or billed to Insurance plans.

| | | |
|---|---|---|
| Osteoporosis | Yes □ No □ | Yes □ No □ |
| Liver Disease | Yes □ No □ | Yes □ No □ |
| Blood Clots | Yes □ No □ | Yes □ No □ |
| Headaches | Yes □ No □ | Yes □ No □ |
| Kidney Disease | Yes □ No □ | Yes □ No □ |
| Diverticulitis | Yes □ No □ | Yes □ No □ |
| Epilepsy | Yes □ No □ | Yes □ No □ |
| Arthritis/joint | Yes □ No □ | Yes □ No □ |
| Constipation | Yes □ No □ | Yes □ No □ |
| Crohn's/IBS | Yes □ No □ | Yes □ No □ |
| Other: Yes □ No □ _____ | | |

Have you ever had a Stress test? Yes □ No □ Date:_____Results:_____
Echocardiogram? Yes □ No □ Date:_____ Results:_____
Catheterization? Yes □ No □ Date:_____ Results:_____

| V. OTC Medication/Supplements (include Aspirin, ibuprofen, antihistamines, sleep aids, laxatives, decongestants, vitamins, minerals, fish oils, protein powders, probiotics, etc.) | | | |
|---|---|---|---|
| Medication Name | Strength | Times per day | Start Date |
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| VI. Lifestyle | | | | | | |
|---|---|---|---|---|---|---|
| List use of: | | Quantity | Daily | Weekly | Monthly | Occasionally |
| Tobacco | No □ Yes □ | _____ | □ | □ | □ | □ |
| Alcohol | No □ Yes □ | _____ | □ | □ | □ | □ |
| Caffeine | No □ Yes □ | _____ | □ | □ | □ | □ |
| Occupation_____ | | Level of Stress : | □Mild | | □ Moderate | □ Severe |
| Marital Status: | | | | | | |
| Who lives in your household? | | | | | | |
| Pets: | | | | | | |
| Hobbies: | | | | | | |
| Travel: | | | | | | |
| Activity level/exercise: | | | | | | |
| Exposure to radiation: | | | | | | |
| Other environmental exposures: | | | | | | |

| VII. Weight Concerns | | |
|---|---|---|
| Lowest Weight: | Current weight: | Height: |
| When did you start gaining weight? | | |
| Have you ever successfully lost weight? When? How | | |
| Have you tracked food intake? Yes □ No □ Did you find it difficult? Yes □ No □ Are you willing to track? Yes □ No □ | | |
| Are you familiar with macronutrients? Yes □ No □ | Do you exercise? Yes □ No □ | |
| Are you happy with your current body weight? Yes □ No □ | Do you eat out? Yes □ No □ | |
| How many meals do you eat daily? | Do you skip meals ? Yes □ No □ | |
| Have you had weight fluctuations of greater than 10 pounds due to dieting? Yes □ No □ | | |
| Please indicate if you tolerate the following foods:<br>□Milk □Yogurt □ Cheese | Food cravings: □salty □ sweets □ fats<br>□ Carbs □ Other:_____ | |
| Indicate daily activity level beyond exercise_____<br>_____<br>_____ | | |
| Describe your typical diet and food choices: | | |
| Breakfast: | | |
| Lunch: | | |
| Dinner: | | |
| Snacks: | | |
| Caffeine: | Carbonated beverages: | |

| VIII. Skin Health | |
|---|---|
| Have you had any Skin Lesions Removed? Yes □ No □ | Do you wear sunscreen? Yes □ No □ |
| Do you bruise easily Yes □ No □ | Do you have dark spots on the face or arms? Yes □ No □ |
| Any change in hair or nails? Yes □ No □ | Any chronic rashes? Yes □ No □ |
| Have you had laser treatments to your faces? Yes □ No □ | Do you experience dryness or wrinkling of skin? Yes □ No □ |
| Describe your skin care routine _____<br>_____<br>_____ | |

| IX. Report of Symptoms | | | | |
|---|---|---|---|---|
| Symptom | Absent | Mild | Moderate | Severe |
| Weight gain | □ | □ | □ | □ |
| Weight loss | □ | □ | □ | □ |
| Diarrhea | □ | □ | □ | □ |
| Constipation | □ | □ | □ | □ |
| Nausea | □ | □ | □ | □ |
| Decreased appetite | □ | □ | □ | □ |
| Cold hands and feet | □ | □ | □ | □ |
| Cramps | □ | □ | □ | □ |
| Increased bleeding/bruising | □ | □ | □ | □ |
| Fluid retention | □ | □ | □ | □ |
| Recurrent infections | □ | □ | □ | □ |
| Shortness of breath | □ | □ | □ | □ |
| Gingivitis | □ | □ | □ | □ |
| Dry skin | □ | □ | □ | □ |
| Skin rashes | □ | □ | □ | □ |
| Brittle nails | □ | □ | □ | □ |
| Headache | □ | □ | □ | □ |
| Stiff muscles | □ | □ | □ | □ |
| Muscle pain | □ | □ | □ | □ |
| Chronic pain | □ | □ | □ | □ |
| Numb/tingling fingers/toes | □ | □ | □ | □ |
| Stress | □ | □ | □ | □ |
| Anxiety | □ | □ | □ | □ |
| Depression | □ | □ | □ | □ |
| Irritability | □ | □ | □ | □ |
| Loss of memory | □ | □ | □ | □ |
| Poor concentration | □ | □ | □ | □ |
| Lack of energy | □ | □ | □ | □ |
| Fatigue | □ | □ | □ | □ |
| Insomnia | □ | □ | □ | □ |
| Dizziness/lightheadedness | □ | □ | □ | □ |
| Decreased sex drive | □ | □ | □ | □ |
| Decrease in ability/frequency to perform sexually | □ | □ | □ | □ |
| Decrease in strength of erections | □ | □ | □ | □ |
| Decrease in # of morning erections | □ | □ | □ | □ |
| Decrease in beard growth | □ | □ | □ | □ |
| Hair loss | □ | □ | □ | □ |
| Increased gray hair | □ | □ | □ | □ |
| Decrease in muscular strength | □ | □ | □ | □ |

| X. Please describe any other information you feel it is important for us to know regarding your health |
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