Integrative Hormone Specialists

Medical History (Male)

Date:_____

Name: _____ Date of Birth _____ Age _____

Height: _____ Weight: _____

Primary Care Doctor Name: _____ Phone Number:_____
Address:_____

Medical Conditions/Diseases: (Please check all that apply.)

____ Heart Disease
____ High Cholesterol or lipids
____ High blood pressure
____ Cancer
____ Ulcers
____ Thyroid Disease
____ Hormone Related Issues
____ Lung Condition
____ Blood clotting problems
____ Diabetes
____ Arthritis or joint problems
____ Depression
____ Epilepsy
____ Headaches/migraines
____ Eye Disease
____ Other:_____

Have you had any of the following performed:

PSA blood test	____ Yes	____ No	Date: _____	Results: _____
Bone Density Test	____ Yes	____ No	Date: _____	Results: _____
Colonoscopy	____ Yes	____ No	Date: _____	Results: _____

Past Surgeries:_____

_____

Current Prescription Medications:

Medication Name	Strength	How often per day	Date Started

Over-the-Counter Medications: (Please list all products you use occasionally or regularly.)

_____
_____

Nutritional/Natural Supplements: (Please identify and list all products you are using.)

_____

_____

Allergies:

Medicine:_____

Food:_____

Environmental:_____

Other:_____

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

Colon Cancer	_____	Family Member(s) _____
Testicular Cancer	_____	Family Member(s) _____
Breast Cancer	_____	Family Member(s) _____
Heart Disease	_____	Family Member(s) _____
Osteoporosis	_____	Family Member(s) _____
Diabetes	_____	Family Member(s) _____
Thyroid Disease	_____	Family Member(s) _____
Alzheimers Dementia	_____	Family Member(s) _____
		How much and how often?

Do you use tobacco? ____ Yes ____ No	_____
Do you use alcohol? ____ Yes ____ No	_____
Do you use caffeine? ____ Yes ____ No	_____
Do you use any other drugs? ___Yes ___ No	If so, what? _____