MALE INTAKE HISTORY

Name:_____ **DOB:**_____ **Date:**____/____/____

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU CURRENTLY

		NO	YES
1.	CONSTITUTIONAL		
	Chills	()	()
	Fatigue	()	()
	Fever	()	()
	Body Aches	()	()
	Night Sweats	()	()
	Weight Gain	()	()
	Weight Loss	()	()
	Other:		
2.	HEENT		
	Ear Drainage	()	()
	Ear Pain	()	()
	Eye Discharge	()	()
	Eye Pain	()	()
	Hearing Loss	()	()
	Nasal Drainage	()	()
	Sinus Pressure	()	()
	Sore Throat	()	()
	Visual Changes	()	()
	Other:		
3.	RESPIRATORY		
	Chronic Cough	()	()
	Cough	()	()
	Known TB Exposure	()	()
	Shortness of Breath	()	()
	Wheezing	()	()
	Other:		
4.	CARDIOVASCULAR		
	Chest Pain	()	()
	Leg Pain with Walking	()	()
	Swelling	()	()
	Palpitations	()	()
	Other:		
5.	GASTROINTESTINAL		
	Abdominal Pain	()	()
	Blood in Stools	()	()
	Change in Stools	()	()
	Constipation	()	()
	Diarrhea	()	()
	Heartburn	()	()
	Loss of Appetite	()	()
	Nausea	()	()
	Vomiting	()	()
	Other:		
6.	GENITOURINARY		
	Dribbling	()	()
	Painful Urination	()	()
	Blood in Urine	()	()
	Excessive Urine Output	()	()
	Slow Stream	()	()
	Urinary Frequency	()	()
	Urinary Frequency	()	()
	Urinary Incontinence	()	()
	Urinary Retention	()	()
	Other:		
7.	REPRODUCTIVE		
	Erectile Dysfunction	()	()
	Penile Discharge	()	()
	Sexual Dysfunction	()	()
	Other:		
8.	METABOLIC/ENDOCRINE		
	Brittle Hair	()	()
	Brittle Nails	()	()
	Cold Intolerance	()	()
	Hair Changes	()	()
	Heat Intolerance	()	()
	Excess Hair Growth	()	()
	Excessive Thirst	()	()
	Increased Appetite	()	()
	Other:		
9.	NEUROLOGICAL		
	Dizziness	()	()
	Extremity Numbness	()	()
	Extremity Weakness	()	()
	Gait Disturbance	()	()
	Headache	()	()
	Memory Loss	()	()
	Seizures	()	()
	Tremors	()	()
	Other:		
10.	PSYCHIATRIC		
	Anxiety	()	()
	Depression	()	()
	Insomnia	()	()
	Other:		
11.	INTEGUMENTARY		
	Contact Allergy	()	()
	Hives	()	()
	Itching	()	()
	Mole Changes	()	()
	Rash	()	()
	Skin Lesion	()	()
	Other:		
12.	MUSCULOSKELETAL		
	Back Pain	()	()
	Joint Pain	()	()
	Joint Swelling	()	()
	Muscle Weakness	()	()
	Neck Pain	()	()
	Other:		

13. HEMATOLOGIC/LYMPHATIC

Easy Bleeding	()	()
Easy Bruising	()	()
Swollen Lymph Glands	()	()

Other: [ ]

14. IMMUNOLOGIC

Environmental Allergies	()	()
Food Allergies	()	()
Seasonal Allergies	()	()

Other: [ ]

RACE:_____
PRIMARY LANGUAGE SPOKEN:_____
ETHNICITY: Non-Hispanic, Hispanic, Non-Latino, Latino

SMOKER: () No () Yes Packs per day _____ Years_____

Former Smoker () No () Yes Packs per day _____ Years_____

Preferred form of contact: Phone () Home () Cell () Mail ()

Preferred Pharmacy Information:

Pharmacy #1_____

Pharmacy #2_____

FAMILY HISTORY

Illness	Yes	Relative	Illness	Yes	Relative
Diabetes			Drinking Problems		
Stroke			Prostate Cancer		
Heart Disease			Colon Cancer		
High Blood Pressure			Breast Cancer		
Other:					

PLEASE LIST ALL MAJOR OPERATIONS

_____
_____
_____
_____

PLEASE LIST ALL CURRENT MEDICATIONS; NAMES AND DOSAGES

_____
_____
_____
_____
_____