



SUNRISE
FUNCTIONAL MEDICINE

Male Health History Questionnaire

(Please print clearly)

Patient Name: _____ **Date:** _____

Birth Date: _____

Weight: _____ **Height:** _____ **Blood Pressure (if known):** _____

Primary Health Concerns:

When did your health concerns begin?

Please share any additional relevant information regarding your health concerns.

Occupation: _____

Please Describe Your Hobbies: _____

Please list current stressors in your life: _____

Pulmonary (Lung)

- ☐ NO PROBLEMS
- ☐ Asthma (wheezing)
- ☐ Chronic bronchitis
- ☐ Chronic cough
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Other _____

Cardiovascular Health

- ☐ NO PROBLEMS
- ☐ Hypertension (high blood pressure)
- ☐ Hypotension (low blood pressure)
- ☐ Heart Attack when? _____
- ☐ By-pass surgery when? _____
- ☐ Angioplasty (balloon) When _____
- ☐ Angina pectoris
- ☐ Tachycardia (rapid heart rate)
- ☐ MVP (Mitral Valve Prolapse)
- ☐ Congestive Heart Failure
- ☐ Heart Palpitations

Circulatory

- ☐ NO PROBLEMS
- ☐ High Cholesterol
- ☐ High triglycerides (fats)
- ☐ Poor arterial circulation
- ☐ Poor venous circulation
- ☐ Leg cramps
- ☐ Tired legs
- ☐ Swollen ankles
- ☐ Varicose veins
- ☐ Numbness of hand or leg
- ☐ Tingling sensations in hands or feet
- ☐ Leg ulcer

Gastrointestinal

- ☐ NO PROBLEMS
- ☐ Problems with digestion
- ☐ Acid indigestion/heartburn
- ☐ Belch after meals
- ☐ Bloating
- ☐ Stomach or duodenal ulcer
- ☐ Loss of appetite
- ☐ Rapid weight gain
- ☐ Rapid weight loss
- ☐ Overweight problem
- ☐ Nausea
- ☐ Pain
- ☐ Pancreas problems
- ☐ Hepatitis gall stones
- ☐ Jaundice (turning yellow)
- ☐ Recurring diarrhea
- ☐ Constipation (compact stools)
- ☐ Leaky gut syndrome

Urinary

- ☐ NO PROBLEMS
- ☐ Recurrent bladder infections
- ☐ Renal (kidney) failure
- ☐ Stress incontinence
- ☐ Kidney stones
- ☐ Chronic fungal infections
- ☐ Weak adrenal glands
- ☐ Female menopause
- ☐ Other _____

Obesity or Weight Loss

☐ Weight at 18? _____

Weight gain or loss?

Endocrine

- ☐ NO PROBLEMS
- ☐ Diabetes mellitus
- ☐ Insulin dependent
- ☐ Non- insulin dependent
- ☐ Thyroid dysfunction
- ☐ Low body temps
- ☐ Depression
- ☐ Overactive
- ☐ Underactive
- ☐ Dry skin
- ☐ Cold hands and/or feet
- ☐ Hair thinning or falling out

Skin

- ☐ NO PROBLEMS
- ☐ Chronic rash
- ☐ Eczema
- ☐ Psoriasis
- ☐ Skin cancer
- ☐ Dandruff or seborrhea
- ☐ Dry skin
- ☐ Oily skin
- ☐ Blemishes (acne)
- ☐ Lupus (SLE)
- ☐ Rosacea
- ☐ Fungal nail infections

Neuro-Psychiatric

- ☐ NO PROBLEMS
- ☐ Frequently nervous or anxious
- ☐ Depression
- ☐ Memory lapses or loss
- ☐ Decreased ability to concentrate
- ☐ Tension headaches/Migraine
- ☐ Sleep disturbances
 - ☐ Trouble falling asleep
 - ☐ Trouble maintaining a restful sleep
- ☐ Chronic or recurrent dizziness
- ☐ Reduced vitality – chronic fatigue
- ☐ Other _____

Cancer (Past or Present) [very important]

- ☐ NO PROBLEMS
- ☐ lung
- ☐ Breast
- ☐ Prostate
- ☐ Brain
- ☐ Colon
- ☐ Stomach
- ☐ Skin
- ☐ Liver
- ☐ Bone
- ☐ Blood (leukemia)
- ☐ Hodgkin's
- ☐ Bladder

☐ Other _____
When first diagnosed _____
Treatment _____

Duration of Treatment _____
Last Checkup _____

Previous Prescription Medications:

Current Prescription Medications:

Anticoagulants? Yes ____ No ____
Since when _____

Sexual Function:

- ☐ NO PROBLEMS
- ☐ Decreased in or loss of libido
- ☐ Decreased sexual vigor
- ☐ Orgasmic Problems

Rheumatoid, Joint and Back:

- ☐ NO PROBLEMS
- ☐ Muscle pains
- ☐ Joint pains
- ☐ Neck pains
- ☐ Back pains
- ☐ Rheumatoid arthritis
- ☐ Lupus (SLE)
- ☐ Scleroderma
- ☐ Fibromyositis or Fibromyalgia
- ☐ Other

General Information:

- ☐ Past or Present Problems with:
- ☐ Medications
- ☐ Foods
- ☐ Soaps
- ☐ Clothing
- ☐ Vaccinations
- ☐ Multiple chemicals
- ☐ Trees
- ☐ Pollens
- ☐ Molds
- ☐ Animals
- ☐ Hay fever
- ☐ Asthma

Supplements Minerals, Herbs or Other:

- ☐ Beer/wine YES___ NO___
☐ Intake per week? _____
- ☐ Hard liquor Yes___ NO___
☐ Intake per week? _____
- ☐ Drugs
- ☐ Cocaine-frequency _____
- ☐ Marijuana-frequency _____
- ☐ Psychedelics-frequency _____
- ☐ Other _____

Operations or Hospitalizations:

Reason	Dates

When were you last ill? _____

Diagnosis: _____

Dental:

Orthodontics? Yes__ No__ If yes, explain

- ☐ Braces
☐ If yes complications? _____
- ☐ Amalgam fillings? How many? _____
- ☐ Root Canals? How many? _____
- ☐ Previous Gum Inflammation (gingivitis)

Social Habits

- ☐ Coffee: How many cups daily? _____
- ☐ Tea: How many cups daily? _____
- ☐ Smoking:
- ☐ Cigarettes How many? _____
- ☐ Cigars How many? _____
- ☐ Pipe How often? _____
- ☐ Vape? How often? _____
- ☐ Alcohol

Nutritional:

- ☐ Do you eat Breakfast?
- ☐ Are you a vegetarian?
- ☐ Anorexia or bulimia

Example of Typical Daily Meals:

Breakfast: _____

Lunch: _____

Dinner _____

Snacks: _____

Beverages: _____

Sleep, Exercise and Relaxation:

How many hours of sleep? _____

Types of exercise _____

MALE REPRODUCTIVE HISTORY & FERTILITY STATUS

Have you had a sperm count? _____ Number (million) _____
% Malformed sperm? _____ % Immotile sperm _____
Clumping? _____

In the past have you had any of the following:

- | | | |
|---|---|---|
| <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Testicular Cancer | <input type="checkbox"/> Testicular Pain |
| <input type="checkbox"/> Testicular Masses | <input type="checkbox"/> Low Libido | <input type="checkbox"/> Varicocele |
| <input type="checkbox"/> Urethritis | <input type="checkbox"/> Vasectomy Reversal | <input type="checkbox"/> Hernias |
| <input type="checkbox"/> Benign Prostatic Hyperplasia | <input type="checkbox"/> Prostate Cancer | <input type="checkbox"/> Sexually Transmitted Disease |

Past Exams and Evaluations:

Date of last prostate exam: _____ Abnormal findings? _____

Please explain: _____

RECENT SCREENINGS AND EXAMS

Date of last blood work: _____ Copy included with clinic paper work: _____

Date of last colonoscopy: _____ Abnormal findings: _____

Please explain: _____

Date of last Bone Density Scan (DEXA Scan): _____

Results: _____

Body Mass Index (BMI): _____ (Easy resources online to calculate BMI)

Diabetes Screening (Fasting glucose, insulin, Hgb A1c, glucose tolerance tests): _____

Please list the date and results: _____

Thyroid Screening: _____ Date and Results? _____

Additional tests, exams or procedures (please list and give dates): _____
