Schneck Integrative Medicine
Dr. Steve Windley

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MALE Personal History Form

Your appointment:

Name: ____ Date of Birth___________________

Family Doctor: ____

Major Symptoms

What brings you in today (major complaint)? ____

How frequent and severe are your symptoms? ____

How long have you had these symptoms? ____

What makes your symptoms worse? ____

What makes your symptoms better? ____

How do your symptoms interfere with your daily life, family life and career?

____

____

____

Please list treatments you have received so far.

What test, medicines and consultations have been done so far?

____

____

____

Have any of these treatments helped?

____

____

Were there any complications with any previous treatments?

____

____

Previous Medical History - Please check any conditions that apply to you.

☐ Hypothyroidism ☐ Poor sex drive ☐ Hypoglycemia ☐ Irritable bowel syndrome

☐ High cholesterol ☐ High blood pressure ☐ Macular degeneration

☐ Diabetes – Please give age of diagnosis ________

☐ Arthritis – Where are you affected?____

☐ Coronary artery disease or heart disease ☐ Heart attack ☐ Stroke

☐ Other medical conditions ____

Surgical History – Please check all that apply.

☐ Tonsil removal ☐ Sinus surgery ☐ Cataracts ☐ Appendix removal

☐Gall bladder removal

☐Joint replacement – Which joints? ______________________________

☐ Other: ____ Blood type: ___________

Medications/Supplements

Please list all prescriptions, over the counter medications, and supplements you currently take.

Medication/Supplement	Dose/Strength	How often you take it

List all known allergies to food, medications, and environment:

Allergy	Reaction

Social History

Who lives at home bedsides you?____

Are they healthy? ____

Marital status:________________ Number of children_______________

Do you use any tobacco products? ☐ Yes ☐ No If yes, how many years? _______________

Are you exposed to second hand smoke often? ☐ Yes ☐ No

Do you have any animals? ☐ Yes ☐ No If yes, what kind and how many?

____

What is your current job?____

Has this or any past job put you around strong chemical or smoke? ☐Yes ☐ No

If yes, please explain:

____

____

Family Medical History
Please check all the appropriate boxes for your family member if any of the following apply.

	Mother	Father	Grandmother	Grandfather	Siblings	Children
Heart disease	☐	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐	☐	☐
Hypothyroidism	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐

If yes to cancer please list what type of cancer and what age it was found:

____

____

Review of Systems - Please check all that apply to you.

Energy-activity

☐ Fatigue ☐ Get tired easily ☐ Wake up tired ☐ Sleep excessively ☐ Weight gain
☐ Put on weight easily ☐ Feel cold at temperatures that others are comfortable ☐Heat intolerance

Mouth, Throat, & Ears

☐ Stuffy nose ☐ Runny nose ☐Hay fever ☐ Frequent sinus infections
☐ Sore throat How many times per year? ______ ☐ Canker sores ☐ Ear infections
☐ Bad breath ☐ Ringing in ears ☐ Hearing loss ☐ Dizzy or lightheaded easily

Eyes

☐ Watering or itchy ☐ Cataracts ☐ Dry eyes ☐ Macular degeneration

Lungs

☐ Wheezing ☐ Asthma ☐ Bronchitis ☐ Chest congestion ☐ Difficulty breathing
☐ Shortness of breath ☐ Hard time breathing while lying down ☐ Ever had a chest xray

Cardiovascular

☐ High blood pressure ☐ Rapid heartbeat ☐ Irregular heartbeat ☐ Chest pain
☐Varicose veins ☐Snore while sleeping ☐Mitral valve prolapse ☐ Swollen feet

Digestive Tract

☐ Constipation ☐ Diarrhea ☐ Belching/gas ☐ Nausea ☐ Bad breath
☐ Heartburn/indigestion ☐ Bloating ☐ Poor sense of taste ☐ Hemorrhoids

☐ Blood in stool ☐ Abdominal pain

Urinary tract/bladder
☐ Kidney/bladder infections ☐ Burning upon urination ☐ Blood in urine
☐ Frequent urination ☐Incontinence ☐ Awake at night to urinate

Joints/Muscles
☐ Joint pain ☐ loss of muscle ☐ Muscle cramps ☐muscle aches ☐ joint swelling

Hormone Axis
☐ Hot flashes ☐ Night sweats ☐ Vaginal dryness/painful intercourse ☐ Tired constantly
☐ Low libido ☐ Fertility issues ☐ Tender breasts ☐ Premenstrual cramping ☐Heavy and/or irregular menses

☐ weight gain in the belly ☐ weight gain in hips ☐ weight gain in spite of good diet?

☐ Cold hands ☐ Cold feet ☐ Dry skin ☐ Dry, coarse brittle hair
☐ Facial puffiness ☐ Feel more tired at rest then when you are active
☐ Low blood pressure ☐ Crave salt ☐ Crave sugar

Head, Emotions & Mind
☐ Headaches - Where does it bother you? ____
☐ Migraine Headaches – How frequent?____
☐Tremor ☐ Restless legs ☐Numbness/tingling
☐ Poor sleep ☐Hyperactivity ☐ Reduction of memory ☐irritable
☐ Cannot think clearly/foggy thinking ☐ Reduction in concentration
☐ Anxious/nervous ☐Depressed ☐ Tearful ☐ Doubt ☐ Sleep light and restlessly
☐Irritability ☐I am stressed out or easily confused ☐ Obsessive/compulsive thoughts

Skin
☐ Cold hands ☐ Cold feet ☐ Dry skin ☐ Hives ☐ Psoriasis ☐ Acne
☐ Loss of hair ☐ Rashes/eczema ☐ Facial puffiness in the mornings
☐ Weak/brital nails ☐ Itching

Specific Health Questions - Please answer/explain as completely as possible.
How much caffeine do your drink daily?____
How many diet drinks do you drink daily?____
Do you crave or over consume:
☐ Sugar (sweets) ☐ Chocolate ☐ Caffeine ☐ Alcohol
Vegetables per day (#) ? ____

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Chemical/Toxin Exposures:
☐cigarette smoke ☐pesticides ☐ mold ☐ anti-perspirants
☐ Strong chemicals ☐ strong odors ☐ lead ☐PCBs ☐ Mercury ☐ ☐

Top Health Goals or Concerns you would like to focus on.

1.____
2.____
3.____