

# Confidential Medical History: Men Page 1

Date \_\_\_\_\_.

Name \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_.

Address: \_\_\_\_\_.

City, State, Zip: \_\_\_\_\_ E-mail: \_\_\_\_\_.

Preferred Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_.

Primary Care Doctor \_\_\_\_\_.

Emerg Contact Name: \_\_\_\_\_ Tel: \_\_\_\_\_ Relationship: \_\_\_\_\_.

*Why are you here today?* \_\_\_\_\_.

\_\_\_\_\_.

\_\_\_\_\_.

Check if you have ever had any of the following problems:

- |   |  |
|---|--|
| <input type="checkbox"/> Heart Trouble                | <input type="checkbox"/> Kidney/Bladder infection                  |
| <input type="checkbox"/> Rheumatic Fever              | <input type="checkbox"/> Allergies/ Sinus                          |
| <input type="checkbox"/> Blood clots in legs or lungs | <input type="checkbox"/> Frequent headaches                        |
| <input type="checkbox"/> High Blood Pressure          | <input type="checkbox"/> Convulsions                               |
| <input type="checkbox"/> Anemia                       | <input type="checkbox"/> Thyroid problems                          |
| <input type="checkbox"/> Blood transfusions           | <input type="checkbox"/> Diabetes                                  |
| <input type="checkbox"/> Bleeding Tendencies          | <input type="checkbox"/> Recent weight change                      |
| <input type="checkbox"/> Pneumonia                    | <input type="checkbox"/> Eating disorder                           |
| <input type="checkbox"/> Tuberculosis                 | <input type="checkbox"/> Cancer                                    |
| <input type="checkbox"/> Gallbladder problems         | <input type="checkbox"/> Depression/psychiatric                    |
| <input type="checkbox"/> Hepatitis/jaundice           | <input type="checkbox"/> Bone/muscle problems                      |
| <input type="checkbox"/> Ulcers                       | <input type="checkbox"/> Artificial joints, heart valve, pacemaker |
| <input type="checkbox"/> Blood in stool/urine         |  |
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> <b>Other:</b>                             |
| <input type="checkbox"/> Stomach/intestinal problems  | <input type="checkbox"/> NONE of the above                         |

Surgeries, Injuries, and Hospitalizations (please include dates):

\_\_\_\_\_.

\_\_\_\_\_.

\_\_\_\_\_.

Medications, herbs, supplements:

NAME	DOSE	REASON USED
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\_\_\_\_\_.

\_\_\_\_\_.

\_\_\_\_\_.

\_\_\_\_\_.

Allergies to Medications:

\_\_\_\_\_.

\_\_\_\_\_.

\_\_\_\_\_.

Family History: Have any of your close relatives had serious medical problems?

\_\_\_\_\_.

\_\_\_\_\_.

\_\_\_\_\_.

## Confidential Medical History: Men Page 2

### Social History:

What is your occupation? \_\_\_\_\_

Do you use tobacco?  yes  no What kind? \_\_\_\_\_ How much? \_\_\_\_\_

How much alcohol do you drink? \_\_\_\_\_

Do you use recreational drugs?  yes  no

Do you have a regular exercise program?  yes  no

Are you on a modified or unusual diet?  yes  no

Marital status:  Single  Married  Widowed  Divorced  Separated

Domestic Partnered  Other

Previous experience with acupuncture? \_\_\_\_\_.

Are there other issues you would like to discuss? \_\_\_\_\_.

revised 9/07