

CLIENT HISTORY FOR MEN

Your answers on this form and the two questionnaires following it will help me understand your health concerns better prior to your first appointment. Best estimates are fine if you cannot remember specific details.

Please print the form and fill it out. Then either scan the form and email it to me at drgedde@natural-hormone-balance.net, or fax it to 775-766-9681. **Thank you!**

Date _____
Last Name _____
First Name _____
Street Address _____
City State Zip _____
Phone _____ Home Work Cell (circle one)
Email Address _____
Age _____

How would you rate your general health? Excellent Good Fair Poor

Chief Concern

What is your main health concern?

How long have you had this concern?

Medications

What medications are you currently taking?
Please list brand or generic name, dose, and how often you take the medication.

What supplements are you taking? Include herbal, vitamin and mineral supplements.

Are you allergic to any medications? Please specify:

Medical History

Please list any chronic illness (diabetes, heart disease, asthma etc.) and how long you have had it:

Have you had prostate or testicular cancer? No Yes

If yes, please give details _____

Do you have a history of infertility? No Yes

If yes, please give details _____

Do you have low bone density? No Yes

If yes, please give details _____

Do you have or believe you may have:

Multiple chemical sensitivities Fibromyalgia Chronic fatigue syndrome

How much have you used antibiotics in your life? Little or none Significant A lot

Please give details _____

Please list any surgeries (type and year): _____

Please list any significant accidents or injuries: _____

Please note any treatment for psychiatric illness (type and year): _____

How healthy were you as a child? _____

How supportive were your parents and environment? _____

Toxic Exposures

Do you smoke / use tobacco? No Yes If yes, please give details _____

How much alcohol do you use, and what kinds? _____

Do you have: Amalgam (mercury-silver) fillings Root canals Dental infections

Do you feel that you use more sugar or caffeine than is good for you? _____

Do you use artificial sweeteners? If yes, please give details _____

What toxic chemicals are you exposed to at work or at home? (exhaust fumes, new carpets) _____

What type of water do you drink? Municipal tap water Private well water Filtered / RO

Life Habits & Situation

Please check any or all of the following that apply to how you eat:

Eat too little Eat too much Get enough protein Get enough healthy fats

Eat processed foods Eat unprocessed foods Eat balanced meals Eat organic

Lots of nonstarchy vegetables Get enough carbohydrate Get too much carbohydrate

Go for a long time between meals Drink plenty of water Don't drink much water

How much do you exercise? _____

How well do you sleep? _____

Please describe your work situation _____

Please describe your home situation _____

How stressful is your life right now? _____

What do you do to relax and have fun? _____

Comments: _____

Family History

Do you have a family history of cancer? No Yes

If yes, please give details _____

Do you have a family history of heart disease? No Yes

If yes, please give details _____

Do you have a family history of osteoporosis? No Yes

If yes, please give details _____

Current Symptoms

Please check the box next to each symptom or sign that you currently have, or have experienced in the past 6 months. On the line next to each that you checked, please note which conditions are most severe or of most concern to you.

Energy, Fluids & Metabolism

- Fatigue _____
- Feeling stressed _____
- Feeling burned out _____
- Decrease in stamina _____
- Decrease in ability to exercise _____
- Difficulty keeping weight on _____
- Unstable blood sugar _____
- Craving for sugar _____
- Craving for salt _____
- Water retention _____
- Unexplained or rapid weight gain _____
- Abdominal weight gain _____
- Inability to lose weight _____
- Elevated cholesterol _____
- Elevated triglycerides _____
- Night sweats _____
- Hot flashes _____
- Always feeling cold _____
- Cold hands and feet _____

Skin / Hair

- Acne or oily skin
- Increase in face or body hair
- Excessive sweating
- Decreased sweating
- Thinning or sagging skin
- Excessively dry skin
- Baldness or loss of head hair
- Thinning beard, pubic hair or body hair
- Thinning eyebrows

Eyes / Ears / Nose / Throat

- Puffiness around or under eyes
- Hoarseness
- Excessive salivation

Cardiovascular

- Palpitations (irregular heartbeat)
- Low blood pressure
- Dizziness / lightheadedness
- High blood pressure

Gastrointestinal

- Heartburn or acid reflux
- Constipation
- Gallbladder problems

Genitourinary

- Decreased sex drive
- Erectile dysfunction
- Decreased urinary flow
- Increased urinary frequency
- Increased urinary urgency
- Painful urination
- Urinary tract infections
- Breast enlargement

Musculoskeletal

- Decreased muscle mass
- Decreased strength
- Decreased bone density
- Aches and pains

Immune System

- Allergies including food allergies

- Chemical sensitivities _____
- Frequent respiratory infections _____

Nervous System

- Insomnia or disturbed sleep _____
- Headaches _____
- Mood swings _____
- Weepiness _____
- Irritability or anger _____
- Indecisiveness _____
- Decreased mental focus _____
- Foggy thinking _____
- Memory lapses _____
- Lethargic depression / apathy _____
- Nervousness / anxiety _____
- Anxious depression _____
- Panic attacks _____
- Numbness in hands or feet _____
- Loss of balance or coordination _____

Vital Signs

Height _____ Current weight _____ What do you feel is your ideal weight? _____
 Blood Pressure (typical reading) _____ Typical heart rate _____ Typical body temp _____

Past Lab Tests

Please indicate the most recent date and result (you may not have had all of these tests):

- | | | |
|---------------------------|------------|--------------|
| Cholesterol | Date _____ | Result _____ |
| Triglycerides | Date _____ | Result _____ |
| Insulin | Date _____ | Result _____ |
| Fasting Glucose | Date _____ | Result _____ |
| Thyroid screen (TSH) | Date _____ | Result _____ |
| Adrenals (DHEA, cortisol) | Date _____ | Result _____ |
| Prostate exam (DRE) | Date _____ | Result _____ |
| PSA (prostate blood test) | Date _____ | Result _____ |
| Bone density | Date _____ | Result _____ |

Dr. Margaret Gedde
 Salida, CO

**Do You Have Low Testosterone?
ADAM, Androgen Deficiency in Aging Men**

1. Do you have a decrease in libido (sex drive)? Yes No
2. Do you have a lack of energy? Yes No
3. Do you have a decrease in strength and/or endurance? Yes No
4. Have you lost height? Yes No
5. Have you noticed a decreased enjoyment of life? Yes No
6. Are you sad and/or grumpy? Yes No
7. Are your erections less strong? Yes No
8. During sexual intercourse, has it been more difficult to maintain your erection to completion of intercourse? Yes No
9. Are you falling asleep after dinner? Yes No
10. Has there been a recent deterioration in your work performance? Yes No

If you answered YES to question 1 or 7, or at least 3 other questions, you may have low testosterone levels.

Morley JE. J Gend Specif Med 2001; 4(2):49-53

International Prostate Symptom Score (IPSS)

Please answer the following questions about your urinary symptoms. Enter your score for each question at the end of each row.

Over the past month, how often have you ...	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	YOUR SCORE
1. ... had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5	
2. ... had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
3. ... stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. ... found it difficult to postpone urination?	0	1	2	3	4	5	
5. ... had a weak urinary stream?	0	1	2	3	4	5	
6. ... had to push or strain to begin urination?	0	1	2	3	4	5	
And finally ...	None	Once	Twice	3 times	4 times	5 times or more	
7. Over the past month, how many times did you most typically get up to urinate for the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5	
Add up your total score and write it in the box.							

The results from this questionnaire will help your doctor assess whether you have an enlarged prostate. This is a common and benign (non-cancerous) condition that often occurs in older men. The results do *not* help to diagnose prostate cancer. In general, you may interpret your score as follows:

- 0-7 indicates mild symptoms
- 8-19 indicates moderate symptoms
- 20-35 indicates severe symptoms