INTEGRATIVE HORMONE
*Specialists*

# Medical History (Male)

Date:_____

Name: _____ Date of Birth _____ Age _____

Height: _____ Weight: _____

Primary Care Doctor Name: _____ Phone Number:_____
Address:_____

**Medical Conditions/Diseases: (Please check all that apply.)**

____ Heart Disease
____ High Cholesterol or lipids
____ High blood pressure
____ Cancer
____ Ulcers
____ Thyroid Disease
____ Hormone Related Issues
____ Lung Condition
____ Blood clotting problems
____ Diabetes
____ Arthritis or joint problems
____ Depression
____ Epilepsy
____ Headaches/migraines
____ Eye Disease
____ Other:_____

**Have you had any of the following performed:**

| | | | | |
|---|---|---|---|---|
| PSA blood test | ____ Yes | ____ No | Date: _____ | Results: _____ |
| Bone Density Test | ____ Yes | ____ No | Date: _____ | Results: _____ |
| Colonoscopy | ____ Yes | ____ No | Date: _____ | Results: _____ |

**Past Surgeries:**_____

_____

**Current Prescription Medications:**

| Medication Name | Strength | How often per day | Date Started |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Over-the-Counter Medications: (Please list all products you use occasionally or regularly.)**

_____
_____

**Nutritional/Natural Supplements: (Please identify and list all products you are using.)**

_____

_____

**Allergies:**

Medicine:_____

Food:_____

Environmental:_____

Other:_____

**Do you have a family history of any of the following?**

| | | |
|---|---|---|
| Colon Cancer | _____ | Family Member(s) _____ |
| Testicular Cancer | _____ | Family Member(s) _____ |
| Breast Cancer | _____ | Family Member(s) _____ |
| Heart Disease | _____ | Family Member(s) _____ |
| Osteoporosis | _____ | Family Member(s) _____ |
| Diabetes | _____ | Family Member(s) _____ |
| Thyroid Disease | _____ | Family Member(s) _____ |
| Alzheimers Dementia | _____ | Family Member(s) _____ How much and how often? |

| | | |
|---|---|---|
| Do you use tobacco? | ____ Yes ____ No | _____ |
| Do you use alcohol? | ____ Yes ____ No | _____ |
| Do you use caffeine? | ____ Yes ____ No | _____ |
| Do you use any other drugs? | ___Yes ___ No | If so, what? _____ |