# OPTIMAL HEALTH MEDICAL INSTITUTE PLLC.
## (CONFIDENTIAL MALE MEDICAL HISTORY)

FULL LEGAL NAME_____ TODAY'S DATE_____
LAST FIRST MI

ADDRESS_____
STREET

_____
CITY STATE ZIP

DOB_____ AGE_____ SEX_____ HEIGHT_____ WEIGHT_____

HOME #_____ WORK #_____ EXT_____ CELL#_____

PREFERRED CONTACT #: HOME WORK CELL

OCCUPATION_____ FT PT RETIRED

LIVING SITUTATION:
SPOUSE____ ALONE____ PARTNER____ FRIENDS____ PARENTS____ CHILDREN____ OTHER____

MARITIAL STATUS: S M D W

PRIMARY PHYSICIAN_____ PHONE NUMBER_____

OTHER PHYSICIANS CURRENTLY SEEING_____

DENTIST_____ PHONE NUMBER_____

IF YOU HAD A REFERRAL, WHO REFERRED YOU?_____

| WHAT ARE YOUR THREE MAIN SYMPTOMS/CONCERNS? | SINCE WHEN? |
|---|---|
| **1.** | |
| **2.** | |
| **3.** | |

**SURGICAL HISTORY**

| TYPE | DATE |
|---|---|
| **1.** | |
| **2.** | |
| **3.** | |
| **4.** | |

| CURRENT MEDICATIONS | STRENGTH | DATE STARTED | DOSAGE PER DAY |
|---|---|---|---|
| **1.** | | | |
| **2.** | | | |
| **3.** | | | |
| **PREVIOUS HORMONES** | **STARTED** | **STOPPED** | **REASON** |
| **1.** | | | |
| **2.** | | | |
| **3.** | | | |

**NUTRITIONAL/ NATURAL SUPPLEMENTS**

| | YES | NO | WHAT KIND? |
|---|---|---|---|
| VITAMINS | | | |
| MINERALS | | | |
| HERBS | | | |
| ENZYMES | | | |
| NUTRITIONAL | | | |
| OTHER | | | |

| ALLERGIES | YES | NO |
|---|---|---|
| PENICILLIN | | |
| CODEINE | | |
| SULFA DRUGS | | |
| MORPHINE | | |
| ASPIRIN | | |
| FOOD ALLERGIES | | |
| DYE ALLERGIES | | |
| NITRATE ALLERGIES | | |
| NO KNOWN ALLERGIES | | |
| PET ALLERGIES | | |
| SEASONAL (POLLEN) | | |
| OTHER: | | |

**CURRENT AND PAST MEDICAL CONDITIONS**

| | YES | NO | DATE OF DIAGNOSIS | | YES | NO | DATE OF DIAGNOSIS |
|---|---|---|---|---|---|---|---|
| **ASTHMA** | | | | **GALLBLADDER TROUBLE** | | | |
| **ARTHRITIS** | | | | **HEART DISEASE** | | | |
| **AUTOIMMUNE DISORDER** | | | | **HIGH BLOOD PRESSURE** | | | |
| **CANCER** | | | | **IRRITABLE BOWEL** | | | |
| **CHRONIC FATIGUE** | | | | **KIDNEY TROUBLE** | | | |
| **CLOTTING DEFECTS** | | | | **LIVER DISEASE** | | | |
| **COLITIS** | | | | **OSTEOPOROSIS** | | | |
| **DENTAL ISSUES** | | | | **STROKE** | | | |
| **DEPRESSION/ANXIETY** | | | | **ULCER** | | | |
| **DIABETES** | | | | **VARICOSE VEINS** | | | |
| **EATING DISORDER** | | | | **VASECTOMY** | | | |
| **EPILEPSY** | | | | **OTHER:** | | | |
| **ERECTILE DYSFUNCTION** | | | | | | | |
| **FRACTURES** | | | | **OTHER:** | | | |
| **FIBROMYALGIA** | | | | | | | |

DIETARY RESTRICTIONS/FOOD CRAVINGS/INTOLERANCES:_____

_____

AVERAGE DAILY MEAL CHOICES:

BREAKFAST:_____ LUNCH:_____ DINNER:_____

DO YOU GET ROUTINE EXERCISE?_____ WHAT TYPE?_____ HOW OFTEN?_____

DO YOU USE TOBACCO PRODUCTS?_____ HOW MUCH?_____ HOW LONG?_____

DO YOU USE ALCOHOL PRODUCTS?_____ HOW MUCH?_____ HOW LONG?_____

DO YOU USE CAFFEINE PRODUCTS?_____ HOW MUCH?_____ HOW LONG?_____

DAILY WATER INTAKE:_____ DO YOU DRINK OR BATHE IN WELL WATER?_____

**FAMILY HISTORY**

| | IMPORTANT DISEASES | LIVING | DECEASED |
|---|---|---|---|
| SONS | | | |
| DAUGHTERS | | | |
| MOTHER | | | |
| FATHER | | | |
| BROTHERS | | | |
| SISTERS | | | |
| AUNTS | | | |
| UNCLES | | | |
| PATERNAL GRANDMA | | | |
| PATERNAL GRANDPA | | | |
| MATERNAL GRANDMA | | | |
| MATERNAL GRANDPA | | | |

**HAVE YOU EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS RECENTLY. PLEASE CHECK THE NUMBER THAT BEST DESCRIBES YOUR EXPERIENCES.**

**1=ABSENT 2=MILD 3=MODERATE 4=SEVERE**

| | 1 | 2 | 3 | 4 | | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|---|---|---|---|
| **HOT FLASHES** | | | | | **NIGHT SWEATS** | | | | |
| **FOGGY THINKING** | | | | | **DEPRESSED** | | | | |
| **APATHY** | | | | | **PROSTATE PROBLEMS** | | | | |
| **DECREASED URINE FLOW** | | | | | **INCREASED URINARY URGE** | | | | |
| **NERVOUS** | | | | | **WEIGHT CHANGES** | | | | |
| **HEADACHES** | | | | | **DECREASED/LOW LIBIDO** | | | | |
| **IRRITABLE** | | | | | **ANXIOUS** | | | | |
| **SLEEPINESS** | | | | | **DECREASED ERECTIONS** | | | | |
| **FATIGUE** | | | | | **ACHES/PAIN** | | | | |
| **HEART PALPITATIONS** | | | | | **DECREASED MENTAL ABILITY** | | | | |
| **ARTHRITIS** | | | | | **DECREASE MUSCLE MASS** | | | | |
| **THINNING SKIN** | | | | | **DECREASED STAMINA** | | | | |
| **BURNED OUT FEELING** | | | | | **LOSS OF SCALP HAIR** | | | | |
| **AGGRESSION** | | | | | **SUGAR CRAVINGS** | | | | |
| **ALLERGIES** | | | | | **STRESS** | | | | |
| **COLD BODY TEMPERATURE** | | | | | **DECREASED CONCENTRATION** | | | | |
| **LOSS OF MUSCLE MASS** | | | | | **INCREASED FORGETFULLNESS** | | | | |
| **MEMORY LAPSES** | | | | | **SEXUAL DYSFUNCTION** | | | | |
| **COLD HANDS AND FEET** | | | | | **CAN'T LOSE WEIGHT** | | | | |
| **HIGH CHOLESTEROL** | | | | | **MOOD CHANGES** | | | | |
| **LOW BLOOD PRESSURE** | | | | | **DECREASED SWEATING** | | | | |
| **HAIR LOSS** | | | | | **HAIR DRY OR BRITTLE** | | | | |
| **NAILS BREAKING OR BRITTLE** | | | | | **INFERTILITY PROBLEMS** | | | | |
| **CONSTIPATION** | | | | | **PANIC ATTACKS** | | | | |
| **INSOMNIA** | | | | | **UNUSUAL SWEATING** | | | | |
| **DECREASED MENTAL SHARPNESS** | | | | | **SHORT ATTENTION SPAN** | | | | |
| **RAPID HEARTBEAT** | | | | | **OTHER:** | | | | |
| **TREMORS IN FINGERS** | | | | | **OTHER:** | | | | |

| OVER-THE-COUNTER (OTC) ISSUES: (OCCASIONALLY OR REGULARLY) | YES | NO |
|---|---|---|
| PAIN RELIEVER | | |
| ASPIRIN | | |
| ACETAMINOPHEN (EX: TYLENOL) | | |
| IBUPROFEN (EX: MOTRIN) | | |
| NAPROXEN (EX: ALEVE) | | |
| KETOPROFEN (EX: ORUDIS KT) | | |
| COUGH SUPPRESSANT (EX: ROBITUSSIN DM) | | |
| ANTIHISTIMINE PRODUCT (EX: CHLOR-TRIMETON) | | |
| DECONGESTANT PRODUCT (EX: SUDAFED) | | |
| COMBINATION PRODUCT COUGH+COLD RELIEF (EX: TRIAMINIC) | | |
| SLEEP AIDS (EX: EXCEDRIN PM, UNISOM, SOMINEX) | | |
| ANTIDIARRHEAS (EX: IMODIUM, PEPTOBISMOL, KAOPECTATE) | | |
| LAXATIVES/ STOOL SOFTNERS (EX: DOXIDAN, CORRECTOL) | | |
| DIET ACIDS/ WEIGHT LOSS PRODUCTS (EX: DEXATRIM) | | |
| ANTACIDS (EX: MAALOX, MYLANTA) | | |
| ACID BLOCKERS (EX: TAGAMENT HB, PEPCID AC, ZANTAC 75) | | |
| OTHER: | | |

## STOP: This section is to be reviewed and completed at OHMI

## General Yearly History Update

I have reviewed my Male Medical History form and have marked below accordingly.

All information is correct/up to date _____ Information needs to be corrected/updated_____
Patient name:_____
Patient signature or Guardian and relationship:_____

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REV.2/2013