

HEALTH HISTORY FOR MEN

Please mark an X on the scales and check any boxes of symptoms you have had in the past month

TEMPERATURE			
How warm / cold you feel (not in degrees); relative to other people do you wear more or less layers, etc.			
COLD			HOT
<input type="checkbox"/> Cold hands or feet <input type="checkbox"/> Chills <input type="checkbox"/> Cold "in the bones" <input type="checkbox"/> Areas of numbness	Thirst for cold / hot drinks <input type="checkbox"/> Thirst, no desire to drink <input type="checkbox"/> Absence of thirst <input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Night sweats <input type="checkbox"/> Unusual sweats <i>When _____ am / pm</i> <i>Where on body _____</i>	<input type="checkbox"/> Hot hands, feet, chest <input type="checkbox"/> Hot flashes <input type="checkbox"/> Hot in afternoon <input type="checkbox"/> Hot at night

MOISTURE			
Your overall body moisture (hair, skin, mouth, bowels, etc.)			
DRY			OILY
<input type="checkbox"/> Dry skin <input type="checkbox"/> Dry hair <input type="checkbox"/> Dry eyes <input type="checkbox"/> Dry brittle nails	<input type="checkbox"/> Dry mouth <input type="checkbox"/> Dry lips <input type="checkbox"/> Dry throat <input type="checkbox"/> Dry nose / Nosebleeds	Edema / Swelling _____ Rashes _____ Itching _____ Dandruff	<input type="checkbox"/> Oily skin <input type="checkbox"/> Oily hair <input type="checkbox"/> Pimples <input type="checkbox"/> Weight gain / loss

DIGESTION			
DIARRHEA			CONSTIPATION
BM: How often? _____ x / every _____ days Stools keep shape? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Alternating diarrhea & constipation (IBS) <input type="checkbox"/> Indigestion	<input type="checkbox"/> Gas <input type="checkbox"/> Bloating <input type="checkbox"/> Belching <input type="checkbox"/> Poor appetite	<input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Bad breath <input type="checkbox"/> Heartburn <input type="checkbox"/> Excessive hunger	<input type="checkbox"/> Dry Stools <input type="checkbox"/> Difficult to pass <input type="checkbox"/> Tired after BM <input type="checkbox"/> Foul smelling stools

ENERGY			
LOW			HIGH
<input type="checkbox"/> Sudden energy drop <i>Time of day: _____ am / pm</i> <input type="checkbox"/> Energy drop after eating <input type="checkbox"/> Fatigue	<input type="checkbox"/> Dependence on caffeine / stimulants <input type="checkbox"/> Wired / ungrounded feeling <input type="checkbox"/> Body / Limbs feel heavy <input type="checkbox"/> Body / Limbs feel weak	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Heart Palpitations <input type="checkbox"/> Blood pressure High / Low <input type="checkbox"/> Bleed / Bruise easy	<input type="checkbox"/> Hard to concentrate <input type="checkbox"/> Poor memory <input type="checkbox"/> Dizziness / lightheaded <input type="checkbox"/> Headaches _____ x / week

SLEEP
hours per night _____
<input type="checkbox"/> Difficulty falling asleep
<input type="checkbox"/> Wake _____ x / night @ _____ am / pm
<input type="checkbox"/> Wake to urinate <i>How often? _____</i>
<input type="checkbox"/> Disturbing dreams
<input type="checkbox"/> Restless sleep
<input type="checkbox"/> Not rested upon waking

EMOTIONS
What emotion(s) dominate your experience?
<input type="checkbox"/> Anger
<input type="checkbox"/> Irritability
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Worry
<input type="checkbox"/> Obsessive thinking
<input type="checkbox"/> Sadness
<input type="checkbox"/> Grief
<input type="checkbox"/> Depression
<input type="checkbox"/> Joy
<input type="checkbox"/> Fear
<input type="checkbox"/> Timid / shy
<input type="checkbox"/> Indecision

EYES, EARS NOSE THROAT
<input type="checkbox"/> Poor vision
<input type="checkbox"/> Night blindness
<input type="checkbox"/> Red eyes
<input type="checkbox"/> Itchy eyes
<input type="checkbox"/> Spots in front of eyes
<input type="checkbox"/> Sinus congestion
<input type="checkbox"/> Phlegm (color _____)
<input type="checkbox"/> Poor hearing
<input type="checkbox"/> Ringing in ears
<input type="checkbox"/> Excess earwax
<input type="checkbox"/> Sore throat
<input type="checkbox"/> Dental problems
<input type="checkbox"/> Mouth sores
<input type="checkbox"/> Cough

URINARY
Fluid in = fluid out? <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Decrease in flow
<input type="checkbox"/> Dribbling
<input type="checkbox"/> Difficulty starting / stopping
<input type="checkbox"/> Incontinence
<input type="checkbox"/> Kidney stones
<input type="checkbox"/> Urgency to urinate
<input type="checkbox"/> Frequent urination
<input type="checkbox"/> Pain on urination
<input type="checkbox"/> Burning sensation
<input type="checkbox"/> Cloudy urine
<input type="checkbox"/> Blood in urine

REPRODUCTIVE
Are you sexually active? <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Change of sexual drive: ↑ ↓
<input type="checkbox"/> Erectile dysfunction
<input type="checkbox"/> Premature ejaculation
<input type="checkbox"/> Sores on genitals
<input type="checkbox"/> Discharge
<input type="checkbox"/> Prostate disease
<input type="checkbox"/> Genital Pain
<input type="checkbox"/> Jock Itch
<input type="checkbox"/> Vasectomy
<input type="checkbox"/> Hernia
<input type="checkbox"/> Hemorrhoids