



Westcoast Women's Clinic for Midlife Health
www.westcoastwomensclinic.com

1003 West King Edward
Vancouver, BC, V6H 1Z3
Phone: 604-738-9601
Fax: 604-738-9605

Adult Male Questionnaire

Today's Date: ____/____/____

Patient Name: _____ Birth date(mm/dd/yy): ____/____/____

Address: _____

City: _____ Prov: _____ Postal: _____

Home Phone: _____ Cellular _____ Work: _____

Email: _____

Occupation: _____

Previous Occupations: _____

Single _____ Married _____ Widowed _____ Divorced _____

Height: _____ Weight: _____

- Do you use tobacco? ____ Yes How much per day? _____ No
- Do you use alcohol? ____ Yes How much per day? _____ No
- Do you use caffeine? ____ Yes How much per day? _____ No
- Tea, Coffee or Chocolate? _____
- Do you use illicit drugs, gamble, view pornography or engage in risk-taking activities? Yes, please describe _____ No: _____
- Do you use artificial sweeteners? ____ Yes What type? _____ No
- Do you drink carbonated beverages? ____ Yes How many per day? _____ No

Allergies: Please check all that apply

____ Penicillin ____ morphine ____ dye allergies ____ seasonal (pollen) allergies
____ Codeine ____ aspirin ____ nitrate allergy ____ no known allergies
____ sulfa drugs ____ food allergies ____ pet allergies ____ other: _____

Please describe the allergic reaction you experienced and when it occurred: _____

Over-the-counter (OTC) issues: Please check all products that you used occasionally or regularly.

____ pain reliever ____ combination products (cough & cold reliever, Triaminic DM®)
____ aspirin ____ sleep aids (Excedrin PC®, Unisom®, Somnex®, Nytol®)
____ acetaminophen (Tylenol®) ____ antidiarrheals (Imodium®, Pepto Bismol®, Kaopectate®)
____ ibuprofen (Motrin IB®) ____ Laxatives / stool softener (Doxidan®, Correctol®)
____ naproxen (Aleve®) ____ Diet aids / weight loss products (Dexatrim®)
____ ketoprofen (Orudis KT®) ____ antacids (Maalox®, Mylanta®)
____ cough suppressant (Robitussin DM®) ____ acid blockers (Tagamet HB®, Pepcid C®, Zantac 75®)
____ antihistamine (Benadryl, Chlor-Trimeton®) ____ others: _____
____ decongestant (Sudafed®)

Nutritional /Natural Supplements: Please check the products you are using & list below

- vitamins (multiple or single vitamins, i.e. B complex, E, C, carotene)
- minerals (calcium, magnesium, chromium, colloidal minerals, single minerals)
- herbs (Ginseng, Ginkgo Biloba, Echinacea, herbal medicinal teas, tinctures, etc.)
- enzymes (digestive formulas, papaya, bromelain, CoEnzyme Q10, etc.)
- nutrition / protein supplements (shark cartilage, protein powders, amino acids, fish oils)
- others (glucosamine, etc.): _____

Vitamin/Mineral Supplement Name	Date Started	Dosage

Describe your eating habits including the times you usually eat: (include desserts)

Breakfast	Lunch	Dinner	Type of Snacks

What foods to you crave?

Medical Conditions / Diseases: Please check all that apply to you.

- | | |
|---|--|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Blood clotting problems |
| <input type="checkbox"/> High cholesterol or lipids (e.g. hyperlipidemia) | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High blood pressure (e.g. hypertension) | <input type="checkbox"/> Arthritis or joint problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Ulcers (e.g. stomach, esophagus) | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Headaches/migraines |
| <input type="checkbox"/> Hormonal related issues | <input type="checkbox"/> Eye disease (e.g. glaucoma, etc.) |
| <input type="checkbox"/> Lung conditions (e.g. asthma, emphysema, COPD) | <input type="checkbox"/> Hernia(s) |
| <input type="checkbox"/> STD's | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Malabsorption (diarrhea, bowel disorders) | <input type="checkbox"/> Allergies |

Please describe any past medical history:

Past Surgeries:

Current Prescription Medications:

Medication Name Reason for Taking? Strength Date Started

How often have you taken antibiotics?

Hormones previously taken Date Started Date Stopped Reason

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

Enlarged Prostate	_____ No	_____ Yes	Family member(s)	_____
Prostate Cancer	_____ No	_____ Yes	Family member(s)	_____
Any Other Cancers	_____ No	_____ Yes	Family member(s)	_____
Heart disease	_____ No	_____ Yes	Family member(s)	_____
Osteoporosis	_____ No	_____ Yes	Family member(s)	_____
Diabetes	_____ No	_____ Yes	Family member(s)	_____
Hypertension	_____ No	_____ Yes	Family member(s)	_____
Allergies/Asthma	_____ No	_____ Yes	Family member(s)	_____
Alzheimer's/Dementia	_____ No	_____ Yes	Family member(s)	_____
Eczema	_____ No	_____ Yes	Family member(s)	_____
Depression	_____ No	_____ Yes	Family member(s)	_____
Mental Illness	_____ No	_____ Yes	Family member(s)	_____
Thyroid	_____ No	_____ Yes	Family member(s)	_____
Autoimmune	_____ No	_____ Yes	Family member(s)	_____

Any other family history we should know about?

Please indicate your symptoms for the following conditions:

	ABSENT	MILD	MODERATE	SEVERE
Prostate problems	_____	_____	_____	_____
Weight Gain	_____	_____	_____	_____
Carbohydrate Craving	_____	_____	_____	_____
Chocolate Craving	_____	_____	_____	_____
Constipation	_____	_____	_____	_____
Dry Skin / Hair	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____
Depression/low mood	_____	_____	_____	_____
Night Sweats	_____	_____	_____	_____
Headaches/Migraines	_____	_____	_____	_____
Irritability/Anger	_____	_____	_____	_____
Mood Swings	_____	_____	_____	_____
Sleep Disturbances/Insomnia	_____	_____	_____	_____
Fluid Retention	_____	_____	_____	_____
Fatigue/low energy	_____	_____	_____	_____
Memory Loss	_____	_____	_____	_____
Incontinence/frequent urination	_____	_____	_____	_____
Decreased urine flow/force	_____	_____	_____	_____
Incomplete emptying	_____	_____	_____	_____
Pain with urination	_____	_____	_____	_____
Back/Leg pain	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Decreased libido	_____	_____	_____	_____
Erections:				
Morning Erections	_____	_____	_____	_____
Difficulty Obtaining	_____	_____	_____	_____
Difficulty Sustaining	_____	_____	_____	_____
Reduced Firmness	_____	_____	_____	_____
Curvature	_____	_____	_____	_____
Other:	_____	_____	_____	_____
Hair Loss	_____	_____	_____	_____
Thyroid Goiter	_____	_____	_____	_____
Heartburn/Indigestion	_____	_____	_____	_____
Diarrhea	_____	_____	_____	_____
Gas/Bloating	_____	_____	_____	_____
Increased Breast tissue	_____	_____	_____	_____
Foggy thinking/decreased clarity	_____	_____	_____	_____
Feeling cold	_____	_____	_____	_____

Lifestyle Questions

1. How often do you exercise? _____

What types: _____

2. During the past 12 months, how often have you felt excessive stress in your life?

Never _____ Occasionally _____ Often _____ Almost always _____

Have you experienced any major losses in life? Yes _____ No _____

If so, please comment:

3. How would you describe your health?

Excellent _____ Very good _____ Good _____ Fair _____ Poor _____

Describe your problems that lead you to this consultation:

What are your goals with this consultation?

Please write down any specific questions you may have.

If possible, please fax or bring any recent lab work or other test results with you. Thank you!