MALE Questionnaire Today's Date: ____________________

THE WOODLANDS INSTITUTE FOR HEALTH & WELLNESS

MILA MCMANUS, MD

Name: ____

REVIEW OF SYMPTOMS

Lifetime Antibiotic Use:

How many times have you used antibiotics over the past year? ____________________

20 years? ____________________

Allergy Treatment:

Have you ever been evaluated by an allergist? ____________________

Food allergies? ____________________

Inhalant allergies? ____________________

Did you ever receive allergy shots? ____________________

Headaches:

Do you have headaches? ____________ How often? _________

What do you take to relieve them? ____

Nose/Eyes:

Do you have sinus problems? ____________

Do you snore? ____________

Do you have post nasal drainage (PND)? ____________ During or after meals? _________

Do you have an itchy nose or eyes? ____________

Do you sneeze often? ____________

Do you have sinus infections? ____________ How often? _________

Do you have a poor/decreased sense of smell? ____________

Ears:

Do you have ear infections? ____________ How often? _________

Do you have poor/decreased hearing? ____________

Do you have dizziness or lightheadedness? ____________ How often? _________

Do you have ringing in the ears? ____________

Mouth:

Do you develop canker sores? ____________ How often? _________

Do you develop fever blisters? ____________ How often? _________

Have you had any wisdom teeth extracted? ____________

Have you had any other teeth extracted? ____________

Do you have mercury amalgam fillings in your mouth? ____________

Have you ever had a root canal? ____________

Throat:

Do you have sore throats? ____________ How often? ___________

Do you have difficulty swallowing on a regular basis? ____________

Lungs:

Do you experience chest congestion and cough? ____________ How often? _________

Asthma:

Do you have asthma? ____________

Seasonally or year round? ____________

Do you generally have tightness in your chest? ____________

Do you generally feel short of breath? ____________

Food History:

Do you consume caffeinated beverages? ____________ How many per day? ___________
Do you consume alcoholic beverages? ____________ How many per week? ___________
Do you crave sweets, breads or salty foods? ____________
Are there any foods that you have an adverse reaction to?
List food and symptoms:

Foods	Symptoms
_____________	________________________________
_____________	________________________________
_____________	________________________________

Please list a typical breakfast: ____
lunch: ____
dinner: ____
snack: ____

Heart:

Do you ever feel your heart skip a beat? ____________ How often? ____________________
For how many years? ____________________
Do you ever have chest pain? ____________ How often? ____________________
For how many years? ____________________
Is the pain sharp, stabbing, dull, or aching? ____________________
Does it radiate to your neck, back, or shoulders? ____________________
How long does the pain last? ____________________

Gastrointestinal System:

Do you have indigestion or heartburn? ____________ How often? ___________
Do you experience abdominal cramping or bloating? ____________ How often? ___________
Do you experience excessive belching or intestinal gas? ____________ How often? ___________
Have you ever had bright red blood in your stools? ____________
Do you have diarrhea often? ____________ How often? ___________
How many times per week do you have a bowel movement? _________
Do you alternate between constipaton and diarrhea? ____________

Urinary Tract:

Have you ever had bladder infections? ____________
Have you ever had kidney infections? ____________
Do you have burning upon urination? ____________
Do you have increased frequency of urination? ____________
Have you ever had a prostate infection? ____________ How many times? ___________
Do you have difficulty stopping or starting your stream of urine? _________
For how many years? _________
Do you have difficulty completely emptying your bladder or have decreased urinary flow? _________
For how many years? _________

Yeast/Skin Fungus:

Do you have problems with a rash in the groin area (jock itch)? _________
Have you had problems with recurrent athlete's foot? ____________
Are your toenails discolored or unusually thickened? ____________

Skin:

Do you have eczema or skin rashes? _________
Location: ____
Do you know the cause of your rashes? ________________________________
Have you ever had hives? ____________
Do you know the cause of your hives? ____________
Do you have dry and/or itchy skin? ____________

Thyroid:

Have you ever been diagnosed with a thyroid disorder? ____________ Year diagnosed _________

If so, was it hyper (high) or hypo (low) thyroid? ____________

Malaise/Fatigue:

Do you feel you should have more energy? ____________

What is your ***average*** energy level on a scale of 1 to 10 with 10 meaning brimming with energy and 1 meaning the inability to get out of bed?

ENERGY LEVEL 1 - 10 ____________/10

Fluid Retention:

Do you have swelling beneath your eyes or dark circles under your eyes? ___________

Do you ever have swelling of your face, hands, or feet? ____________

Cold Sensitivity:

Do you have cold hands or feet? ____________

Are you sensitive to the cold or get chilled easily? ____________

Sweating:

Do the palms of your hands or feet perspire excessively? ____________ For how many years? _________

Do you have decreased perspiration? ____________ For how many years? ___________

Hair Condition:

Do you have coarse or fine hair? ____________

Have you ever had significant hair loss? ____________ How long? _________ months

_________ years

Weight:

Have you had significant weight gain? ____________ How many pounds? ___________

Since what year? ____________

Do you have difficulty losing weight? ____________

Cognitive Ability:

Do you feel that you have decreased mental sharpness? ____________ For how many years? _________

Do you have a poor short-term memory? ____________ For how many years? _________

Mood:

Do you ever feel discouraged, blue, or depressed? ____________

What percent of the time? ____________% For how many years? _________

Have you ever taken anti-depressants? ____________

Which one(s)? ____

Between what ages? ____________ and ___________

Joint Function:

Do you have pain in any joint(s)? ____________

_________ Neck ____________ Shoulder

_________ Wrists ____________ Hips

_________ Ankles ____________ Elbows

_________ Lower Back ____________ Knees

_________ Finger joints ____________ Toe joints

Muscle:

Do you ever have any numbness or tingling in the extremities? _________

Which ones? ____

Do you have muscle weakness? ____________

Do you ever have diffuse muscle aches? ____________

Do you ever have cramping in your muscles? ____________

Which muscles? ____

Sleep:

Do you have insomnia or restless sleep? ____________

Libido:

Have you had a decrease in sexual desire? ____________

General Well Being:

How you noticed any of the following, or a decline in any of the following:

________	Initiative	________	Decisiveness
________	Assertiveness	________	Abstract Thinking
________	Confidence	________	Analytical Ability
________	Goal Orientation	________	Muscle Mass
________	Mood Swings	________	Muscle Strength

For how many years? ____________

Current Medications:

Do you currently take any medications? **(Include prescription, over-the-counter, vitamins, supps)**

Please list the medication, strength, times/day taken and number of years taken:

1 ________________________________
2 ________________________________
3 ________________________________
4 ________________________________
5 ________________________________
6 ________________________________
7 ________________________________

Past Medical History:

Yes/No	Illnesses	Year	
________	Cancer	________	Type: ____________
________	Chronic Fatigue Syndrome	________	
________	Colitis	________	
________	Diabetes	________	
________	Elevated Cholesterol	________	
________	Elevated Triglycerides	________	
________	Fibromyalgia	________	
________	Gall Bladder Disease	________	
________	Heart Disease	________	
________	Hepatitis	________	
________	HIV Positive	________	
________	Hypertension	________	
________	Hyperthyroidism	________	
________	Hypothyroidism	________	
________	Irritable Bowel Syndrome	________	
________	Kidney Disease	________	
________	Lupus	________	
________	Mitral Valve Prolapse	________	
________	Mononucleosis	________	
________	Multiple Sclerosis	________	
________	Oral Yeast/Mouth Infection	________	
________	Osteoporosis/Osteopenia	________	
________	Pelvic Inflammatory Disease	________	
________	Pneumonia	________	
________	Seizures	________	
________	Sexually Transmitted Disease	________	Type: ____________
________	Sleep Apnea	________	
________	Stroke	________	
________	Tuberculosis	________	
________	Ulcerative Colitis	________	

Drug Allergies: (Please list all drug allergies, and what your reaction is to each medication)

1 ______________________ 4 ______________________
2 ______________________ 5 ______________________
3 ______________________ 6 ______________________

Surgical Procedures:

What surgeries have you had?	Year(s)
1	
2	
3	
4	
5	

Family History:

	Age	Medical Problem(s)
Father - alive or deceased?		
Mother - alive or deceased?		
Brothers/sisters:		
Children:		

Social History:

Do you currently smoke? __________ Are you a former smoker? __________
How many packs per day? __________ How long? __________
How many cigars per day? __________ How long? __________
What year did you quit smoking? __________
Do you chew or dip tobacco? __________ For how many years? __________

What is your occupation? ______________________________

Pets:

Do you have any pets? __________ Cat __________ Dog __________
Other ______________________
Are the pets indoor, outdoor, or both? __________

Chief Complaint:

What are your primary concerns? ______________________________