Pure Health Natural Medicine-Male Intake

Male Intake

Date: _____

Personal Information

Name: *(first, last)* _____ Preferred Name: _____

Sex: M F Date of Birth: _____ Age: _____

Street Address: _____

City: _____State:_____ Zip: _____ E-mail _____

Home Phone: _____ Cell Phone: _____

Employer: _____

Occupation: _____ Work Phone: _____

Name of Spouse or Guardian: _____

Employer: _____Work Phone: _____

Last Physician Consulted: _____

Reason for that visit: _____

Emergency Contact:

Name: _____ Phone: _____

Who may we thank for referring you? *(fill in and/or circle all that apply)*

Friend _____ Professional Referral _____ Event _____

Internet Flier/Brochure Ad

What are your top health concerns?

1. _____

2. _____

3. _____

Current Medications:

Include prescription, over the counter, and any supplements.

Rx	**Vitamins/Herbs**

Drug Allergies: _____

Other Allergies: _____

Habits *(please list type, frequency and quantities)*:

Caffeine: _____

Alcohol: _____

Smoking: _____

Exercise:

Type:

Days per week:

Cross training:

Weight training:

Competitive events:

Number of competitions per month/year:

Training group/coach:

Diet *(Please list typical foods eaten at these meals)**:***

Breakfast:

Lunch:

Dinner:

Snacks:

Fluids:

Please list any foods that you avoid.

Past Medical History:

Childhood Illnesses: _____

Adult Illnesses: _____

Hospitalizations: _____

Surgeries: _____

Injuries: _____

Family Health History: *(cause of death and age, where applicable)*

Mother:

- Grandmother:
- Grandfather:

Father:

- Grandmother:
- Grandfather:

Siblings:

What is your heritage? _____

Are you adopted? Yes No

Current and Past Health:

Blood type? _____ Current Weight: _____ Weight 1 year ago: _____

Maximum Weight: _____ Minimum Weight: _____

Please circle any symptoms/conditions that you have had or currently experiencing.

Night sweats	Hoarseness	Black stool
Fatigue/tiredness	Dental problems	Polyps
Weight problems	swollen glands	Gallbladder stones
Appetite changes	Neck pain	Pain with urination
Fever	Easy bleeding or bruising	Urinary frequency
Eczema	History of anemia	dribbling
Hair Loss	Pain when breathing	frequent bladder infections
Skin tags	Shortness of breath	Kidney stones
Acne	History of positive tuberculosis	Blood in urine
Skin rash	Asthma	Foul smelling urine
Headaches	Chest pain/discomfort	varicose veins
Migraine	High blood pressure	Pain in legs with walking
Head injury	Rheumatic fever	Swelling of legs
Eye pain	Heart murmur	Joint pain or stiffness
Double vision	Ankle swelling	History of broken bones
Tearing problems	Dizzy spells	Muscle cramps or spasms
Floaters in eyes	Heart fluttering	Weakness
Hearing loss	Trouble swallowing	Depression
Ringing	Heartburn	Insomnia
Earache	Ulcer history	Mood swings
Dizziness	Abdominal pain	Anxiety
Frequent colds	Nausea	Nervousness
Nose bleeds	Vomiting	Phobias
Sinus problems	Blood in stool	Suicidal thoughts/plans
Bloody nose	abdominal bloating	Family hx- psychiatric disorders
Hay fever/allergies	Belching	Thyroid problems
Loss of smell	Gas	Diabetes
Snoring	Hemorrhoids	Hypoglycemia
Frequent sore throat	Hepatitis	Weight gain
Sore tongue	Constipation	Weight loss
Mouth sores	Diarrhea	

Male Specific:

Loss of muscle mass	Erectile difficulties	Loss of penile sensations
Urinary urgency	Anorgasmia*(no orgasm)*	Testicular pain
Loss of sex drive	Premature ejaculation	Decreased force of urine flow
Hair loss	Nightime urination_____per night	

Please list any other symptoms/conditions, not listed above: