

MALE HEALTH HISTORY AND NEUROTOXIC QUESTIONNAIRE

GENERAL INFORMATION

Name: _____

Date: _____

Address _____ Phone # (h) _____ (c) _____

_____ Email Address _____

_____ Age _____ Date of Birth _____

Status Married Separated Divorced Widowed Single Partnership

Live with Spouse Partner Parents Children Friends Alone

Education _____

Occupation _____ Hours per week _____ Retired

Employer _____ Work Address _____

In case of emergency, who should we contact?

Name _____ Relationship _____

Address _____ Phone _____

COMPLAINTS/CONCERNS

Please list your chief symptoms in order of decreasing severity, starting with the worst one. Please note how long each symptom has been present.

Problem	Onset	Frequency	Severity
1. e.g. Headaches	June 2007	4 times per week	Mild / moderate / severe
2.			
3.			
4.			
5.			
6.			
7.			

ALLERGIES

Medication/Supplement/Food

Reaction



IMMUNIZATION HISTORY

Have you received any vaccinations in the last 5 years? Yes ___ No ___ If yes, please list: _____

DENTAL HISTORY

Do you currently have any amalgam, silver, metal, and/or gold fillings? Yes ___ No ___ If yes, how many? _____

If yes, please list which kinds: _____

How long have you had these fillings? _____

If you do not have any fillings in your mouth, have you had any fillings removed in the last 12 months? Yes ___ No ___

Have you had any dental work done in the last 12 months? Yes ___ No ___

MEDICATIONS AND SUPPLEMENTS

Medications: Please list any medications that you are currently taking or have taken in the last month, including antibiotics, non-prescription drugs, and prescription drugs.

Supplements: List all vitamins, minerals and other nutritional supplements that you are currently taking.

Medication Name	Dosage

Supplement Name/Brand	Dosage

Have your medications or supplements ever caused you unusual side effects or problems?

Yes ___ No ___ If yes, please describe: _____

SLEEP/REST

Average number of hours you sleep > 10 8 – 10 6 – 8 < 6

Do you have trouble falling asleep? Yes ___ No ___

Do you rested upon awakening? Yes ___ No ___

Do you have problems with insomnia? Yes ___ No ___

Do you snore? Yes ___ No ___ Explain: _____



LIFESTYLE INDICATORS

TOBACCO HISTORY

Currently using tobacco? Yes ___ No ___ How many years? _____ Packs per day: _____

If yes, what type? Cigarette _____ Smokeless _____ Cigar _____ Pipe _____ Patch/Gum _____

Previous smoking: How many years? _____ Packs per day: _____

Are you exposed to 2nd hand smoke? If yes, please explain: _____

ALCOHOL INTAKE

How many drinks currently per week? *1 drink = 5 oz wine, 12oz beer, 1.5 oz spirits*

None ___ 1 – 3 ___ 4 – 6 ___ 7 – 10 ___ > 10 ___

Previous alcohol intake? Yes ___ (Mild ___ Moderate ___ High ___)

CAFFEINE INTAKE

How many cups of coffee per day? None ___ 1 – 3 ___ 4 – 6 ___ 7 – 10 ___

How many cans of soda per day? None ___ 1 – 3 ___ 4 – 6 ___ 7 – 10 ___

Is the soda you drink, diet soda? Yes ___ No ___

SYMPTOMS

Symptoms	Mild	Moderate	Severe	Additional Comments
Body/joint aches				
Weight gain				
Weight loss				
Elevated blood pressure				
Elevated cholesterol				
Digestive problems				
Head hair loss				
Dry skin/thinning skin				
Constant hunger				
Sweet cravings				
Caffeine cravings				
Salt cravings				
Anger/aggression				
Irritability				
Low mood/Depression				
Concentration problems				
Foggy thinking				
Increased fatigue				
Lowered libido				
Erectile Dysfunction				
Frequent need to urinate				



Symptoms	Mild	Moderate	Severe	Additional Comments
Pain with urination				
Bone loss/Osteoporosis				
Low blood sugar				
Other:				

MISCELLANEOUS

Have you had a vasectomy? Yes No When? _____

Have you had a reverse vasectomy? Yes No When? _____

Have you experienced symptoms related to the vasectomy? Yes No Explain _____

Do you have a history of prostate problems? Yes No Explain _____

Date of last Prostate Exam _____

Most recent PSA results _____ Date _____

How often do you exercise? Never Rarely Sometimes Regularly

Other information for us to know: _____

How did you hear about our Wellness and Nutrition Program?

What is your major complaint and when did these symptoms begin?



Please list your current and past health conditions (i.e. Diabetes Mellitus, etc.)

Is there anything in your medical history that you consider to be relevant?

What is your employment history? Please provide brief summary.

Please list all past surgeries and the condition each surgery was for.

Please explain your housing history (type of homes, where and when).



PATIENT HISTORY

Answer the following questions to the best of your ability. If you don't know the answer, simply leave it blank.

MERCURY

- Yes No Do you have amalgam (silver) fillings in your teeth?
- Yes No Have you ever had them in the past?
- Yes No Did your mother have amalgam when pregnant with you?
- Yes No Have you ever worked in a dental office? If so, how long? _____
- Yes No Have you had any dental crowns, bridges, root canals, dry sockets or infected tooth extractions?
- Yes No Do you have any dental implants or other metal in your mouth?
- Yes No Did you wear contact lenses during the 1980's or early 1990's?
- Yes No Did you take oral contraceptives during the 1980's or early 1990's?
- Yes No Did you receive yearly flu shots or have you recently received a flu shot, allergy shot or a vaccination?
- Yes No Have you noticed any adverse reactions to these shots?
- Yes No Do you have any tattoos with red ink?
- Yes No Do you eat large amounts (more than twice a week) of tuna, shark, swordfish or Atlantic Salmon?

LEAD

- Yes No Does your occupation involve soldering, metal salvage, old home repair or sandblasting?
- Yes No Was your home built before 1978?
- Yes No Have you ever worn cosmetics containing kohl?

GENERAL TOXICITY

- Yes No Have you ever lived near, on or by a golf course, freeway or tension wires? If yes, please explain.

- Yes No Have you ever had any chemical exposures? (I.e. cleaning chemical spills, working in a beauty salon, etc.)

MOLD

- How old is the house you are living in? _____ How long have you lived there? _____
- Yes No Do you see mold growing at home, work or school?
- Yes No Have you ever had water damage at home, work or school?
- Yes No Does your home, workplace or school have a damp or mildew smell?



- Yes No Does spending time in your basement cause of worsen your symptoms?
- Yes No Does your basement ever get wet?
- Yes No Does spending time in a different location for at least a few days cause a noticeable decrease in your symptoms?

LYME DISEASE

- Yes No Have you ever been diagnosed with Lyme Disease?
- Yes No Have you ever been bitten by a tick or recluse spider?
- Yes No Have you ever seen a bulls-eye rash appear on any part of your body?
- Yes No Did the bulls-eye rash appear shortly after following a tick, spider bite or time spent outdoors?
- Yes No Was your mother ever diagnosed with Lyme Disease?
- Yes No Do you frequently go camping, hunting or are you involved in outdoor activities (specifically in wooded or grassy areas)?

HEALTH HISTORY

- Yes No Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities?
- Yes No Does anyone in your family experience similar symptoms to yours?
What is your birth order (i.e. first born, second, third, etc.)? _____
- Yes No Do you have any history of kidney dysfunction?
- Yes No Do you or any immediate family member have a history with cancer?
- Yes No Do you have any history of heart disease, myocardial infarction (heart attack), etc.?
- Yes No Are you currently having any thoughts of suicide?
- Yes No Have you ever been diagnosed with bipolar disorder, schizophrenia or depression?
- Yes No Do you have a history of strokes?
- Yes No Have you ever been diagnosed with diabetes mellitus?
- Yes No Have you ever been in an auto accident, fallen or received a major physical injury?
- Yes No Are you in menopause?
- Yes No Do you have any allergies to food or medications.



Name: _____

Date: _____

Rate each of the following symptoms to the best of your ability based upon your typical health profile over the last year. If you cannot answer a question, simply leave it blank.

Point Scale

0 = Never had the symptoms

2 = Occasionally have it, severe effect

4 = Frequently have it, severe effect

1 = Occasionally have it, mild effect

3 = Frequently have it, mild effect

Anxiety
Mood swings
Enraged behavior or anger for no reason
Excessive shyness, timidity, social phobia (not typical to your personality)
Irritability (not typical to your personality)
Low body temperature (below 97.5)
Insomnia (can't get to sleep or return to sleep)
Dizziness
Sound in ears (ringing or hearing your heart beat)
Psychological symptoms, even thoughts of suicide
Sensitivity to sound
Indecisiveness
Feeling of being overwhelmed or fearful
Metallic taste in your mouth
Bad breath
Bleeding gums
Sensitive teeth
Canker sores or other sores in the mouth
Floater, shadows or swimmers when you read or look into the sky
Dyslexia or loss of place while reading, even as a child
Swelling eyelids
Peeling on top layer of skin (hands, feet)
Dry skin
Heart pain (angina) and you are under 45 years old
Depression
Gout (arthritic pain, especially in big toes)
Pain in shoulders or upper back
Twitching eyelids
Anemia (low iron/hemoglobin on blood test)
Wrist/ankle drop or weak extensor muscles
Hair falls out (not normal male pattern baldness)
Trouble processing new information

Sensitivity to light
Fatigue after exercising (feeling worse)
Bad night vision or seeing halos around lights
Shortness of breath, with very little effort
Excessive thirst and/or frequent urination
Red eyes or tearing
Blurred vision at times
Morning stiffness
Sensitivity to smells, including chemicals such as petrochemicals, perfumes, air fresheners
Chronic fatigue or weakness
Non-restful sleep
Receive static shock more often and w/more dramatic effect than normal (doorknobs, car, light switch, people, etc.)
Word reversal or trouble finding words
Sensitivity to touch
Short-term memory loss
Chronic sinus congestion
Dry-non productive cough
Muscle twitching
Excessive sweating, especially at night
Joint pain - not necessarily true arthritis - can move from joint to joint
Difficulty losing weight regardless of diet or exercise
Persistent fungal or viral infection, including athlete's foot, warts, jock itch, candidiasis
Frequent illness, prolonged illness or sick days
Numbness or weakness in arms and legs
Headaches
Trouble adding or dividing numbers in your head
Fluctuating constipation and diarrhea
Stomach pain for no apparent reason
Appetite swings
Frequent muscle aches, cramps, unusual sharp sudden pains
Rashes or rosacea
Cold extremities

