

Dr. Shel Wellness & Medical Spa
Men's Consultation & Exam

Date: _____ Referral: _____ Email: _____
Name: _____ Home: _____ Cell: _____
Address: _____ City: _____ State: _____
DOB: _____ AGE: _____ Martial Status: M W D S Occupation: _____
Reason for Visit: _____

Please check all applicable and explain:

↑ Excessive Weight	↑ Hepatitis	↑ Mental Health/Depression
↑ Chronic Fatigue Syndrome	↑ HIV Positive	↑ Mitral Valve Prolapse
↑ Colitis	↑ Hypertension	↑ Multiple Sclerosis
↑ Diabetes	↑ Hyperthyroidism	↑ Elevated Cholesterol
↑ Hypothyroidism	↑ Seizures	↑ Vertigo
↑ Elevated Triglycerides	↑ Kidney Disease	↑ Sleep Disorders
↑ Heart Disease	↑ Irrit. Bowel Syndrome	↑ Skin Complaints

Health Maintenance: (Date last Exam) _____

Bone Density: _____ Physical Exam: _____ PSA: _____

Lipid Profile: _____ Flex Sigmoidoscopy _____

Td: _____ Influenza: _____ Pnuemovax: _____

Medical Problems: (Explained from above) _____

Current Medications/Supplements: _____

Do you have any drug allergies? ↑ No ↑ Yes If Yes explain _____

Do you exercise? ↑ No ↑ Yes What kind? _____ How Often _____

Do you smoke? ↑ No ↑ Yes How much? _____ How Long? _____

Do you use alcohol? ↑ No ↑ Yes How much? _____ How Long? _____

Have you had a major illness/hospitalization/surgery? ↑ No ↑ Yes
Explain: _____

Is there a family history of: (Please check)

↑ Colon Cancer	↑ Prostate Cancer	↑ Diabetes	↑ Lung Cancer
↑ High Blood Pressure	↑ Heart Disease	↑ Other _____	

Are you interested in our other services:

↑ Nutritional testing	↑ Laser Rejuvenation	↑ Cellulite Treatment
↑ Weight Management		
↑ Laser Hair Removal	↑ Laser Skin Tightening	↑ Lymphatic Massage

Drug Allergies

To what drugs are you allergic?

- 1. _____ 2. _____ 3. _____
- 4. _____ 5. _____ 6. _____

Family History

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

REVIEW OF SYMPTOMS

Heart

- Y N** Do you ever feel your heart skip a beat? How often? _____
For how many years? _____
- Y N** Do you have chest pain? How often? _____
For how many years? _____
Is the pain sharp / stabbing / dull / aching? Does it radiate to your neck, back, or shoulders?
- Y N** How long does the pain last? _____
- Y N** Do you feel like you are going to pass out?

Gastrointestinal System

- Y N** Do you have abdominal cramping, bloating, excessive belching or intestinal gas?
How often? _____ x/week _____ How long? _____

Urinary Tract

- Y N** Have you ever had bladder infections / kidney infections?
How many x/year? _____ For how many years? _____
- Y N** Have you ever had kidney stones? How many times? _____
Year of last episode _____
- Y N** Do you have burning upon urination?
- Y N** Do you have increased frequency of urination?

Skin

- Y N** Do you have any unexplained skin rashes or itchy skin?
How long? _____ months _____ years
Do you know the cause of your rashes/itchy skin? _____

Thyroid

- Y N** Have you been diagnosed with a thyroid disorder? Year diagnosed _____

Y N Were you diagnosed with hyperthyroidism
Y N Were you diagnosed with hypothyroidism
Y N Did you ever take thyroid medication? What year did you quit? _____
Name of medicine _____ Dose _____ mg

Malaise/Fatigue

Y N Do you feel you should have more energy?
What is your average energy level on a scale of 0 to 10 with 10 meaning brimming
with energy
and 1 or 2 meaning the inability to get out of bed?
ENERGY LEVEL 0-10 ____ /10 For how many years? _____

Hair Condition

Y N Do you have coarse or fine hair? For how many
years? _____
Y N Have you ever had significant hair loss?
How long? _____ months _____ years

Weight

Y N Have you had significant weight gain? How many
pounds? _____
Since what year? _____
Y N Do you have difficulty losing weight? How long? _____

Mood

Y N Do you ever feel discouraged, blue or depressed more than 10% of the time?
What percent of the time? ____ % For how many years? ____
Y N Have you ever taken anti-depressants?
Which one(s)? _____
Between what ____ y.o. and ____ y.o.
ages? _____

Skin

Y N Do you have dry skin? For how many years? ____

Sleep

Y N Do you have insomnia or restless sleep? How many
years? _____
How many
Y N Do feel tired after a full night's sleep? years? _____
Y N Do you have afternoon fatigue?
How many hours of sleep do you _____ hours/night?
require? _____

Dr. Shel Wellness & Medical Spa
Male
Hormone Checklist

Check applicable symptoms of each category:

Androgen Deficiency

- | | |
|--|--|
| <input type="checkbox"/> Low libido | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Thinning Pubic Hair |
| <input type="checkbox"/> Aches/Pains/Arthritis | <input type="checkbox"/> Decreased Muscle Mass |
| <input type="checkbox"/> Memory Lapses | <input type="checkbox"/> Bone Loss |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Thinning Skin |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Fibromyalgia |

Androgen Excess

- | | |
|---|--|
| <input type="checkbox"/> Excessive Facial Hair | <input type="checkbox"/> Oily Skin |
| <input type="checkbox"/> Excessive Body Hair | <input type="checkbox"/> Ovarian Cysts |
| <input type="checkbox"/> Increased Acne | <input type="checkbox"/> Hair Loss scalp |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Nervous/Irritable |
| <input type="checkbox"/> Elevated Triglycerides | |

Cortisol Deficiency

- | | |
|---|---|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Cold Body Temp. |
| <input type="checkbox"/> Sugar Cravings | <input type="checkbox"/> Irritable |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Chemical Sensitivity | <input type="checkbox"/> Heart Palpitations |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Aches / Pains |

Cortisol Excess

- | | |
|---|--|
| <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> Heart Palpitation |
| <input type="checkbox"/> Bone Loss | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Weight Gain/Loss | <input type="checkbox"/> Cold Body Temp |
| <input type="checkbox"/> Muscle Mass Loss | <input type="checkbox"/> Sugar Cravings |
| <input type="checkbox"/> Thinning Skin | <input type="checkbox"/> Low Libido |
| <input type="checkbox"/> Elevated Triglycerides | <input type="checkbox"/> Hair Loss |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Increased Facial Hair |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Increased Body Hair |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Memory Lapse | <input type="checkbox"/> Nervous |

Thyroid Deficiency

- | | |
|--|---|
| <input type="checkbox"/> Tired or Exhausted | <input type="checkbox"/> Difficult to Concentrate |
| <input type="checkbox"/> Sad or Depressed | <input type="checkbox"/> Mood Changes |
| <input type="checkbox"/> Cold Body Temp. | <input type="checkbox"/> Swelling/Puffy eye/face |
| <input type="checkbox"/> Cold Hands & Feet | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Slow Pulse Rate |
| <input type="checkbox"/> Can't Lose Weight | <input type="checkbox"/> Decreased Sweating |
| <input type="checkbox"/> Memory Lapse | <input type="checkbox"/> Hair Dry/ Brittle |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Hair Loss |
| <input type="checkbox"/> Nails breaking/ Brittle | <input type="checkbox"/> Infertility Problems |
| <input type="checkbox"/> Aches / Pains | <input type="checkbox"/> Slowed Reflexes |
| <input type="checkbox"/> Low Libido | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Heart Palpitation | <input type="checkbox"/> Thick Tongue |
| <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> Slow Ankle Reflex |
| <input type="checkbox"/> Bone Loss | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Decreased Muscle Mass | |
| <input type="checkbox"/> Thinning Skin | |