

# Men's Consultation



*Dr. Shel*  
WELLNESS & MEDICAL SPA

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                 | ↑ Hypothyroidism        | ↑ 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) \_\_\_\_\_

Name and number of Primary Care Physician: \_\_\_\_\_

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    | ↑ Weight Management   |
| ↑ Allergy Testing     | ↑ Laser Hair Removal    | ↑ Massage             |
| ↑ Weight Management   | ↑ Laser Skin Tightening | ↑ Laser Hair Regrowth |

**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? \_\_\_\_\_  
**Y N** Do feel tired after a full night's sleep? How many years? \_\_\_\_\_  
**Y N** Do you have afternoon fatigue?  
How many hours of sleep do you \_\_\_\_\_ hours/night?  
require? \_\_\_\_\_

# Male Hormone Checklist



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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          |

## **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      |

## **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           |   |

## **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 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               |

