Please submit your questionnaire to the Men's Comprehensive Health Institute by:

Fax: (210) 450-4970 or

Mail: UT Medicine
C/O Myra Joseph, RN
8300 Floyd Curl Drive
Mail Code 8332
San Antonio, TX 78229

Questions? Contact the Men's Health Nurse at 210.450.6400

UT MEDICINE
HEALTH SCIENCE CENTER SAN ANTONIO

Questionnaire

Last Name: First Name: DOB:

Current Address:

Daytime Phone #: Evening Phone #:

Current Occupation:

How did you hear about us?

General Questions:

Do you have a primary care physician? yes ☐ no ☐

If yes please provide physician name and location (phone/fax number:

Height: Weight:

Date of your last annual physical examination:

Are you *(Mark with and x):* Single ☐ Married/Gender of Spouse M or F ☐ Divorced ☐ Widowed ☐

Do you have children? How many? yes ☐ no ☐

How many sexual partners now? How many sexual partners in lifetime?

How would you describe your overall health?

Past Medical History and Immediate Family History

(i.e. parents, grandparents, siblings)

	Self		Family Member		
	Yes	No	Yes	No	
I was adopted	☐	☐	☐	☐	Which:
Anemia	☐	☐	☐	☐	Which:
Anxiety	☐	☐	☐	☐	Which:
Asthma	☐	☐	☐	☐	Which:
Arthritis (Osteoarthritis)	☐	☐	☐	☐	Which:
Autoimmune Disorder	☐	☐	☐	☐	Which:
Blood Clot (in a vein or in lung)	☐	☐	☐	☐	Which:
Cancer/Type/Age at Diagnosis	☐	☐	☐	☐	Which:
Cirrhosis of Liver	☐	☐	☐	☐	Which:
Clotting Disorder	☐	☐	☐	☐	Which:
COPD	☐	☐	☐	☐	Which:
Congenital Heart Disease	☐	☐	☐	☐	Which:
Coronary Artery Disease	☐	☐	☐	☐	Which:
Crohn's /Ulcerative Colitis	☐	☐	☐	☐	Which:
Cystic Fibrosis	☐	☐	☐	☐	Which:
Diabetes Type 1 (Juvenile onset)	☐	☐	☐	☐	Which:
Diabetes Type 11 (Adult onset)	☐	☐	☐	☐	Which:
Dementia	☐	☐	☐	☐	Which:
Depression	☐	☐	☐	☐	Which:
Difficulty Sleeping	☐	☐	☐	☐	Which:
Diverticulosis	☐	☐	☐	☐	Which:
Heart Attack (MI)	☐	☐	☐	☐	Which:

Past Medical History and Immediate Family History

(i.e. parents, grandparents, siblings)

	Self		Family Member		
	Yes	No	Yes	No	
Heartburn (Acid Reflux/GERD)	☐	☐	☐	☐	Which:
Hemochromatosis	☐	☐	☐	☐	Which:
Hepatitis A	☐	☐	☐	☐	Which:
Hepatitis B	☐	☐	☐	☐	Which:
Hepatitis C	☐	☐	☐	☐	Which:
HIV/AIDS	☐	☐	☐	☐	Which:
High Blood Pressure	☐	☐	☐	☐	Which:
High Cholesterol	☐	☐	☐	☐	Which:
History of illegal drug use	☐	☐	☐	☐	Which:
Infertility Problems	☐	☐	☐	☐	Which:
Irregular Heartbeat	☐	☐	☐	☐	Which:
Irritable Bowel Syndrome	☐	☐	☐	☐	Which:
Kidney Disease	☐	☐	☐	☐	Which:
Kidney Stones	☐	☐	☐	☐	Which:
Mental Retardation	☐	☐	☐	☐	Which:
Osteopenia (thin bones)	☐	☐	☐	☐	Which:
Osteoporosis	☐	☐	☐	☐	Which:
Peptic Ulcer Disease	☐	☐	☐	☐	Which:
Peripheral Vascular Disease	☐	☐	☐	☐	Which:
Sexually Transmitted Disease	☐	☐	☐	☐	Which:
Stroke/TIA	☐	☐	☐	☐	Which:
Transfusions (blood products)	☐	☐	☐	☐	Which:
Urinary Symptoms (Refer to other questionnaire under forms)	☐	☐	☐	☐	Which:
Varicose Veins	☐	☐	☐	☐	Which:

Past Surgical History *(please list any surgeries that you had in the past, including dates):*

Current Prescribed Medications *(list all medications that you are currently taking prescribed by a physician, include dosage and how often taken):*

List any of the following that you currently take:

Over-the-counter medications (aspirin, Tylenol, stool softeners, Phazyme, etc.)

Herbal remedies/supplements (Black Cohosh, Hoodia, etc.)

Vitamin/mineral supplements (Os-Cal, Vitamin C with Rose Hips, etc.)

Do you take any herbal supplements as medication (St. John's Wort, Soy, Licorice, etc)? If yes, please list.

Fen-phen or any other diet pills yes ☐ no ☐ when and how long:
Hormone replacement therapy yes ☐ no ☐ when and how long:

Are you allergic to any of the following? *(if yes please explain the reaction you had)* *(List)*

Food yes ☐ no ☐
Medications yes ☐ no ☐
Bee Stings yes ☐ no ☐
Shellfish/Iodine yes ☐ no ☐

Do you use tobacco products? never ☐ currently ☐ Date quit?

second-hand smoking ☐

If currently smoking cigarettes: packs per day
If currently smoking cigars: pieces per week
If currently using smokeless tobacco: packs per day

Do you ever drink alcohol? yes ☐ no ☐
Average drinks per day *(mark with an x):* 0 <1 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ >4 ☐

Preventive care *(indicate most recent date and results if known):*

Colonoscopy/Colon Polyps/Adenomas yes ☐ no ☐ date: normal ☐ abnormal ☐
Bone density yes ☐ no ☐ date: normal ☐ abnormal ☐
Cholesterol profile yes ☐ no ☐ date: normal ☐ abnormal ☐

Circle ones that apply:
(Dermatology evaluation for melanoma or Adenomas) yes ☐ no ☐ date: normal ☐ abnormal ☐
normal ☐ abnormal ☐

Are you currently suffering from any of the following *(please mark with an x)?*

Palpitations *(irregular or rapid heartbeat sensations)*	yes ☐	no ☐
Chest pain	yes ☐	no ☐
Arm pain	yes ☐	no ☐
Syncope	yes ☐	no ☐
Loss of consciousness	yes ☐	no ☐
Dizzy spells	yes ☐	no ☐
Fatigue	yes ☐	no ☐
Profuse diaphoresis *(sweating)*	yes ☐	no ☐
Leg swelling	yes ☐	no ☐
Shortness of breath	yes ☐	no ☐
Dyspnea on exertion *(difficulty walking due to shortness of breath)*	yes ☐	no ☐
Lower extremity claudication *(difficulty walking due to leg cramps)*	yes ☐	no ☐
Nausea/Vomiting	yes ☐	no ☐
Back or neck pain	yes ☐	no ☐
Shoulder, knee or hip pain	yes ☐	no ☐
Seasonal allergies	yes ☐	no ☐
Diarrhea	yes ☐	no ☐
Constipation	yes ☐	no ☐
Abdominal pain	yes ☐	no ☐
Heartburn	yes ☐	no ☐
Rectal bleeding	yes ☐	no ☐
Gas/bloating	yes ☐	no ☐
Urinary or Fecal Incontinence	yes ☐	no ☐
Hernia	yes ☐	no ☐

Immunizations and Travel *(indicate date if known):*

Flu	yes ☐	no ☐	date:
Tetanus/ TDAP	yes ☐	no ☐	date:
Pneumonia	yes ☐	no ☐	date:
Hepatitis A@B	yes ☐	no ☐	date:
MMR *(measles/mumps/rubella)*	yes ☐	no ☐	date:
Shingles or Meningitis	yes ☐	no ☐	date:

If you lived or traveled outside of the US please list where and date.

Do you think you could be at increased risk of HIV infection? yes ☐ no ☐

Through your occupation were you exposed to any of the following?

Chemicals	yes ☐	no ☐	date:
Asbestos	yes ☐	no ☐	date:

Physical activity

☐ Very active (>5 days/week)
☐ Active (3-5 days/week)
☐ Somewhat active (1-2 days/week)
☐ Not exercising at all

Are you safe in your home? yes ☐ no ☐

Are you interested in receiving an eye exam? yes ☐ no ☐

Are you interested in dental services at UT Dentistry next to the MARC? yes ☐ no ☐

Do you have vision or dental insurance? yes ☐ no ☐

Please provide us with a copy of your insurance card with forms submitted.

Cosmetic Procedures - Would you be interested in a consult about any of the following cosmetic procedures*?

Nonsurgical anti-aging treatments: yes ☐ no ☐

(i.e. Botox, Restylane, Juvederm, fat grafts or Obagi Rejuvenating skin treatments)

Body contouring: yes ☐ no ☐

(i.e. removing unwanted fat or excess skin with liposuction or tummy tuck procedures)

Weight reduction surgery? yes ☐ no ☐

Please list any prior surgery to your prostate (i.e. biopsy, radiation, TURP or Interstim Implant)

Cosmetic services are reasonably priced but may not be covered by insurance.
We will verify your insurance benefits and co pays of your coverage.

Thank you for completing this questionnaire. We will contact you to discuss your personal itinerary for your exams and verify your insurance benefits,as well as any out of pocket charges you would be responsible for prior to your services.

Fax your completed questionnaire and Patient Registration forms to:
210-450-4970

Mail to:
Men's Comprehensive Health Institute
C/O Myra Joseph, RN
8300 Floyd Curl Drive
Mail Code 8332
San Antonio, TX 78229

Questions: Contact the Men's Health Nurse at 210.450.6400