Questionnaire Form

Please submit your questionnaire to the Men's Comprehensive Health Institute by:
Fax: 210-450-4970 or **Mail:** UT Health Physicians, 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

Personal Information

Last Name _____ First Name _____ DOB _____

Current Address _____ City _____ State _____ Zip Code _____

Daytime Phone # _____ Evening Phone # _____

Email Address _____ SSN# _____

How did you hear about us? _____

Emergency contact _____

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 an x)*: ☐ Single ☐ Married Gender of Spouse *(circle one)* M or F ☐ Divorced ☐ Widowed

Do you have children? ☐ Yes ☐ No If yes, how many? _____

How many sexual partners now? _____

How would you describe your overall health? _____

Past Medical History and Immediate Family History *(i.e. parents, grrandparents, siblings)*

CONDITIONS	SELF		FAMILY MEMBER		WHICH FAMILY MEMBER?
	Yes	No	Yes	No	
I was adopted	☐	☐	☐	☐	
Anemia	☐	☐	☐	☐	
Anxiety	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	
Arthritis *(Osteoarthritis)*	☐	☐	☐	☐	
Autoimmune Disorder	☐	☐	☐	☐	
Blood Clot *(in a vein or in lung)*	☐	☐	☐	☐	
Cancer/Type/Age at Diagnosis	☐	☐	☐	☐	
Cirrhosis of Liver	☐	☐	☐	☐	
Clotting Disorder	☐	☐	☐	☐	
COPD	☐	☐	☐	☐	
Congenital Heart Disease	☐	☐	☐	☐	
Coronary Artery Disease	☐	☐	☐	☐	
Crohn's /Ulcerative Colitis	☐	☐	☐	☐	
Cystic Fibrosis	☐	☐	☐	☐	
Diabetes Type 1 *(Juvenile onset)*	☐	☐	☐	☐	
Diabetes Type 11 *(Adult onset)*	☐	☐	☐	☐	
Dementia	☐	☐	☐	☐	
Depression	☐	☐	☐	☐	
Difficulty Sleeping	☐	☐	☐	☐	
Diverticulosis	☐	☐	☐	☐	
Heart Attack *(MI)*	☐	☐	☐	☐	
Heartburn *(Acid Reflux/GERD)*	☐	☐	☐	☐	
Hemochromatosis	☐	☐	☐	☐	
Hepatitis A	☐	☐	☐	☐	

CONDITIONS	SELF		FAMILY MEMBER		WHICH FAMILY MEMBER?
	Yes	No	Yes	No	
Hepatitis B	☐	☐	☐	☐	
Hepatitis C	☐	☐	☐	☐	
HIV/AIDS	☐	☐	☐	☐	
High Blood Pressure	☐	☐	☐	☐	
High Cholesterol	☐	☐	☐	☐	
History of illegal drug use	☐	☐	☐	☐	
Infertility Problems	☐	☐	☐	☐	
Irregular Heartbeat	☐	☐	☐	☐	
Irritable Bowel Syndrome	☐	☐	☐	☐	
Kidney Disease	☐	☐	☐	☐	
Kidney Stones	☐	☐	☐	☐	
Osteopenia *(thin bones)*	☐	☐	☐	☐	
Osteoporosis	☐	☐	☐	☐	
Peptic Ulcer Disease	☐	☐	☐	☐	
Peripheral Vascular Disease	☐	☐	☐	☐	
Sexually Transmitted Disease	☐	☐	☐	☐	
Stroke/TIA	☐	☐	☐	☐	
Transfusions *(blood products)*	☐	☐	☐	☐	
Urinary Symptoms *(Refer to other questionnaire under forms)*	☐	☐	☐	☐	
Varicose Veins	☐	☐	☐	☐	

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)*

Food ☐ Yes ☐ No _____

Medications ☐ Yes ☐ No _____

Bee Stings ☐ Yes ☐ No _____

Shellfish/Iodine ☐ Yes ☐ No _____

Do you use tobacco products ☐ Never ☐ Currently ☐ Second-hand smoking Date quit _____

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)* ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 4 or more

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

Dermatology evaluation (*Circle ones that apply)*

Melanoma or Adenomas ☐ Yes ☐ No Date _____ ☐ 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	Hepatitis A and B	☐ Yes	☐ No
Tetanus/ TDAP	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No
MMR (measles/mumps/rubella)	☐ Yes	☐ No	Shingles or Meningitis	☐ Yes	☐ No

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) ☐ Somewhat active (1-2 days/week)

☐ Active (3-5 days/week) ☐ Not exercising at all

Are you safe in your home?	☐ Yes	☐ No	Are you interested in dental services at UT Dentistry next to the MARC?	☐ Yes	☐ No
Are you interested in receiving an eye exam?	☐ 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: (i.e. Botox, Restylane, Juvederm, fat grafts or Obagi Rejuvenating skin treatments) ☐ Yes ☐ No

Body contouring (i.e. removing unwanted fat or excess skin with liposuction or tummy tuck procedures) ☐ Yes ☐ No

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 or 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