Adult Male Questionnaire

Dr. Jacqueline Chirco

Patient Name: _____ Date of Birth: ____/____/_____ Age: _____
Date: ___/____/____

Address: _____

Cell Number: _____

Home Number: _____

Email Address: _____

Emergency Contact & Number: _____

Other Physicians you see:

Name: _____ Name: _____

Phone: _____ Phone: _____

How did you hear about us? _____

Top 5 problems or reasons for today's visit:

1._____

2._____

3._____

4._____

5._____

Allergies (Food/Pollen/ Medications/Pets):

_____ _____

_____ _____

Name: _____ Date: ___/___/____

Current Medications/ Supplements (Please include Brand Name)	**Dose**	**# of Times / Day**

Name: _____ Date: ____/____/____

Marital Status & Relationships:

Single: _____ Married: _____ Widowed_____ Divorced: _____

Social support systems? _____(friends/church/etc)

Stressful relationships? _____

Who do you live with? _____

Occupation/job title? _____

Stress level: _____ (Use 1/10 rating system)

Major life stressors:

_____

_____

What do you do to relieve stress? _____

Spiritual background? _____

Tobacco:

Current use? _____ (yes/no) Packs per day: _____

Past use? _____ (yes /no) Packs per day :_____

Year quit: _____

Vape use:

Current use? _____ (yes/no) Number of pods a day:_____

Past use? _____ (yes/no) Number of pods a day:_____

Recreational drugs:

Substance name? _____ (marijuana, heroin, cocaine, etc.)

Current use? _____(yes/no) How much and how often?:_____

Name: _____ Date:____/____/____

Alcohol Usage:

Do you drink alcohol? _____ (yes/no) How many drinks/day?_____

How often do you drink? _____ number/week Do you get drunk?_____

Favorite type of alcohol used? _____

Have you ever tried to stop drinking? _____

Do you Exercise? _______

Type of exercise_____ (ex: walking/jogging/swimming/etc)

How much & how often? _____

Do you enjoy exercise? _____

Pets: _____

Diet/ beverages: _____

Do you drink coffee/tea? _____ How many cups /day? _____

Do you drink Energy Drinks? _____(yes/no) - example, "Monster" Drinks.

Number of Energy Drinks/ day? _____

Food Craving? (carbs/salt/chocolate/etc)

_____

Average breakfast: _____

Average lunch: _____

Average dinner: _____

Average snack(s): _____

Name :_____ Date:___/___/___

Personal and Family History (Check all that apply):

Condition	**Yourself**	**Father**	**Mother**	**Sibling(s)**	**Grandparent(s)**	**Children**
Heart Disease (Heart Attacks/ Heart Failure,etc)						
High Cholesterol						
High Blood Pressure						
Stroke						
Blood Clots						
Bleeding Problem(s)						
Asthma/ Emphysema						
Infectious Diseases (HIV/Hepatitis/COVID-19/etc)						
Stomach/Intestinal Problems (Ulcers/Colitis/Diverticulitis/IBS, etc)						
Thyroid Problems						
Diabetes						
Stress/Anxiety						
Adrenal Gland Problems						
Problems with Hormone Imbalances						
Depression						
Schizophrenia						
Bipolar Disorder						
ADD/ ADHD						
Seizures						

Name: _____ Date:___/___/___

Personal and Family Medical History (Check all that apply):

Condition	**Yourself**	**Father**	**Mother**	**Siblings**	**Grandparent(s)**	**Children**
Headaches						
Memory Problems						
Dementia						
Cataracts						
Glaucoma						
Eczema/Rashes						
Kidney Problems						
Gum Disease						
Osteoporosis						
Colon Cancer						
Breast Cancer						
Ovarian Cancer						
Lung Cancer						
Prostate Cancer						
Thyroid Cancer						
Other Cancer(s)						
AutoImmune Diseases (M.S. R.Arthritis, Lupus, etc,)						
Other Illnesses not listed?						

Name: _____ Date:___/____/____

Please check off any symptoms you are currently experiencing. If you answer "yes," check off the degree you are experiencing each problem.

Are you experiencing?	Yes	Mild	Moderate	Extreme	No
Weight Gain					
Weight Loss					
Feeling Puffy					
Sleep Problems					
Fevers					
Night Sweats					
Nausea/ Vomiting					
Change in Appetite					
Heart Racing					
Irregular Heart Beats					
CHEST pain or tightness					
Short of Breath					
Cough					
Spitting up phlegm					
Spitting up blood					
Blood in Urine					
Increase Urination					
Pain with Urination					
Inflammation/Body Aches/ Achy Joints					

Name: _____ Date:____/___/_____

Please check off any symptoms you are currently experiencing. If you answer "yes," check off the degree you are experiencing each problem.

Are you experiencing?	**Yes**	**Mild**	**Moderate**	**Extreme**	**No**
Neck Pain					
Back Pain					
Gas/ Indigestion					
Burping					
Pain in stomach after eating					
Changing bowel movements (diarrhea/ constipation)					
Blood in stool					
Dark tar-like stools					
Heartburn					
Stomach pain after eating					
Salt Craving					
Sugar/Carb Cravings					
Hair Loss					
Fatigue/ Lack of Energy					
"Wired" or too much energy					
Depressed/ Moody/ Irritable					
Anxiety					
Brain Fog					
Not feeling refreshed after sleeping					

Name:_____ Date:___/____/___

Past Surgical History:

Surgery Type:	**Date/Year**	**Reason:**

Medical Records:

Date of most recent Complete Physical ___/_____/____ (Physician_____)

Date of most recent Colonoscopy ___/____/_____ (Physician_____)

Date of most recent PSA ___/___/_____

Are you experiencing any of the following?

Please check all that apply:

Lack of motivation ____ Shortness of breath ____

Depression ____ Chest pain _____

Low self-esteem ____ Decreased libido _____

Muscle weakness ____ Erectile dysfunction _____

Mental fog _____ Poor memory _____

I have answered each question truthfully and had time to review questions and answers with Dr. Chirco.

_____(patient printed name)

_____(patient signature) **Date: _____/____/____**

_____ **Date: ____/_____/____**

Jacqueline Chirco, D.O.