## Men's Health Clinic. Introductory Questionnaire

Please answer the following questions which will your doctor to individualise your check up. All information provided remains completely confidential. Name: Address: Date of birth: **General Lifestyle Questions** Do you smoke? ☐ Previously ☐ Yes □ No How often do you drink alcohol? □ Daily ☐ 1-2 Times a week ☐ 3-4 Times a week ☐ Weekly ■ Monthly How often do you exercise? □ Daily ☐ 1-2 Times a week ☐ 3-4 Times a week ☐ Weekly ☐ Monthly What type of exercise do you take? ☐ Other \_\_\_\_\_ □ Walking ☐ Running ☐ Golf ☐ Gym How many portions for fruit/vegetables do you eat per day?  $\square$  0 □ 1 - 2 □ 3-4 □ 4 - 5 ☐ More than 5

How many po	rtions of sweets, cake	es, chocolates, ar	nd biscuits do you	eat per day?
□ 0	□ 1-2	□ 3-4	□ 4-5	☐ More than 5
Do you feel st	ressed due to your w	ork, home life or	financial pressure	es?
Yes □	No □	Intermittent	ly 🗆	Regularly □
Medical His	tory			
Have you ever	suffered from? (PI	ease tick relevan	t boxes)	
☐ Heart atta	ack or Angina			
☐ Rheumati	c Fever			
☐ High Blood	d Pressure			
☐ High Chole	sterol			
☐ Asthma				
☐ Bronchitis /	<sup>'</sup> Emphysema			
☐ Cancer	Please specify type			
☐ Thyroid Dis	order			
☐ Allergies				
☐ Migraine				
☐ Blackouts /	Seizures			
☐ Stroke / M	ini – stroke			
If you have a f	amily history of any o	of the conditions	above, please pro	vide details below

If you have ever been hospitalised in the past or had an below	ny operatior	ns, please pro	ovide details	
Please list any medication that you are currently being treatments such as herbal remedies	prescribed	or taking as o	over the counter	
Male Wellbeing				
Do you regularly examine your testicles?	Yes 🗆	No □		
Have you ever had any lumps or swelling in your testicles?	Yes □	No □		
Do you get up at night to pass urine on a regular basis?	Yes □	No □		
If yes, how many times a night?				
Have you noticed any change in the flow, rate or stream of	your urine?	Yes □	No □	

Do you ever have a prostate examination / PSA (prostate) blood test? Yes ☐ No ☐
Do you have pain on passing urine? Yes □ No □
Do you ever have blood in your urine? Yes □ No □
Do you ever have any problems with erections? Yes □ No □  Intermittently □ Regularly □
Would you like to discuss anything related to sexual health? Yes ☐ No ☐
General Health
General Health  Is there any other aspect of your health that you would like to discuss? Yes □ No □
Is there any other aspect of your health that you would like to discuss? Yes $\ \square$ No $\ \square$

Thank You