In-Depth Medical Health Consult Form for Men

Please fill out the form below at least 4 days before your appointment for Dr. Frame to review.You may pause, save your answers and come back to the questionnaire at any time.

Name *

Phone *

Email *

Nickname or how you prefer to be addressed:

Add an email you prefer to be contacted through:

Family Doctor

Doctor Phone Number

Your current occupation and employer.

Employer Phone Number

I give permission to use this email address for communication of personal information. *

(•) Yes ( ) No

Please indicate if you want copies of your reports sent to another doctor. Doctors Name

Doctor Phone Number

Emergency contact person

Emergency Contact Number

Specialists or alternative medical persons involved in your care/Chiropractor/Naturopath etc.

Medical History

Medical History

Fill in only what applies to you.

High Blood Pressure: When were you diagnosed?

Details

Cancer: When were you diagnosed?

Details

Diabetes or pre-Diabetes: When were you diagnosed?

Details

Digestive System (eg: ulcers, lactose intolerance, colitis, diverticulitis, IBS). When?

Any issues with ears, nose, throat or eyes?

Details

Heart Disease: Blocked arteries, valve issues, heart failure. When were you diagnosed?

Details

Liver and Gallbladder (eg. Gall stones, hepatitis, cirrhosis): When?

Details

Lung Disease (eg: recurrent pneumonia, bronchitis, asthma, emphysema). When?

Details

Kidney Disease (eg: Chronic kidney disease, UTI's, stones). When?

Details

Psychiatric and Psychological Problems (eg: depression, anxiety, panic attacks, psychosis) When?

Details

Neurological Disorders (eg: dementia, memory, MS, neuralgia, stroke) When?

Details

Muscle, Bone and Joint Disorders. When?

Details

Prostate problems. When?

Details

Addictions and Substance Abuse. When?

Details

Generalized Disease (eg: Lupus, AIDS, Chronic Fatigue Syndrome, anemia, Lyme disease) When?

Details

Genetic Problems

Allergies:
○ Yes ◉ No

Food Allergies:
○ Yes ◉ No

List Foods you are Allergic to:

Drug Allergies:
○ Yes ◉ No

List Drugs you are Allergic to:

Enviromental Allergies:
○ Yes ◉ No

List Enviromental Allergies: (eg: Grass, mold, etc)

Anthropomorphic Details: (Your Physical Details)

My current weight is:

Do you consider yourself:
◉ Overweight ○ Underweight

If so, by how much?

My height is:

Neck Circumference:

Waist Circumference:

Hip Circumference:

Past Medical History

Fill in only what applies to you

Surgeries: Day Surgery and Year

Major Surgery and Year

Surgeries: Day Surgery and Year

Major Surgery and Year

Other Hospital Admissions: Reason & Year

Other Hospital Admissions: Reason & Year

Family Health History

Mother: Deceased
○ Yes ◉ No

Age:

Illness:

Father: Deceased
○ Yes ◉ No

Age:

Illness:

Siblings
◉ Brother ○ Sister

Age:

Illness:

Siblings
◉ Brother ○ Sister

Age:

Illness:

Siblings
◉ Brother ○ Sister

Age:

Illness:

Siblings:
◉ Brother ○ Sister

Age:

Illness:

Maternal Grandmother: Deceased
○ Yes ◉ No

Age:

Illness:

Maternal Grandfather: Deceased
○ Yes ◉ No

Age:

Illness:

Paternal Grandmother: Deceased
○ Yes ◉ No

Age:

Illness:

Paternal Grandfather: Deceased

Yes No

Age:

Illness:

Maternal Uncles: Deceased

Yes No

Age:

Illness:

Age:

Illness:

Maternal Aunts: Deceased

Yes No

Age:

Illness:

Age:

Illness:

Paternal Uncles: Deceased

Yes No

Age:

Illness:

Age:

Illness:

Paternal Aunts: Deceased

Yes No

Age:

Illness:

Age:

Illness:

Health Maintenance

Have you had a comprehensive wellness exam or program recently?

Yes No

What was the date of your most recent? (Aproximate date is fine.)

Complete Physical:

Diabetes Test:

Cholesterol Test:

Occult Stool Blood Test:

Colonoscopy:

Sigmoidoscopy: (Procedure used to see inside the sigmoid colon (large intestine) and rectum.)

Rectal or Prostate Examination:

Genital (or Self) Examination:

Diet:

Diet Evaluation Which best describes your current diet?

◉ Vegetarian ○ Low Fat ○ High Protein ○ Gourmet ○ Fast Food ○ Low Carb ○ Diabetic ○ Weight loss

Have you tried weight loss diets in the past?

○ Yes ◉ No

Type of diet(s) you have tried?

Were they Successful?

○ Yes ◉ No

Estimate the average servings per day of the following: Fruit:

Green Vegetables:

Fiber Foods:

Dairy Products:

Exercise:

Exercise

◉ I exercise regularly ○ I don't exercise

○ I used to exercise

Number of years since I exercised

Aerobic exercise: How many times per week?

Stretching exercise: How many times per week?

I do weight training exercise: How many times per week?

I do sports exercise: How many times per week?

Do you have a gym membership?

Do you have a personal trainer?

○ Yes ◉ No ○ Yes ◉ No

Systematic Questionnaire

Rate from 0-4, how much you are dealing with these issues?

	0	1	2	3	4
Losing hair	○	○	○	○	○
Problems focusing eyes	○	○	○	○	○
Face rashes	○	○	○	○	○
Hearing loss	○	○	○	○	○
Nose bleeds	○	○	○	○	○
Indigestion or heartburn	○	○	○	○	○
Swallowing problems	○	○	○	○	○
Shortness of breath	○	○	○	○	○
Cough	○	○	○	○	○
Chest pain	○	○	○	○	○
Abdominal pain	○	○	○	○	○
Diarrhea	○	○	○	○	○
Constipation	○	○	○	○	○
Passing gas	○	○	○	○	○
Urinary problems	○	○	○	○	○
Nail problems	○	○	○	○	○
Difficulty exercising	○	○	○	○	○
Back or neck problems	○	○	○	○	○
Joint pain, muscle weakness	○	○	○	○	○
Low energy	○	○	○	○	○
Sadness	○	○	○	○	○
Sleep problems	○	○	○	○	○
Poor concentration	○	○	○	○	○
Mood swings	○	○	○	○	○
Anger	○	○	○	○	○

Irritability or nervousness	
Weight loss	
Weight gain	
Swollen fees, wrists or ankles	
Poor skin healing	
Skin tears easily	
Swollen glands	
Recurrent colds and infections	
Prolonged infections	

International Prostate Symptom Score (IPSS)

Rate from 0-4: How much are you dealing with these issues?

	0	1	2	3	4
Incomplete emptying: Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?					
Frequency: Over the past month, how often have you had to urinate again less than two hours after you finished urinating?					
Intermittency: Over the past month, how often have you found you stopped and started again several times when you urinated?					
Urgency: Over the last month, how difficult have you found it to postpone urination?					
Weak stream: Over the past month, how often have you had a weak urinary stream?					
Straining: Over the past month, how often have you had to push or strain to begin urination?					
Nocturia: Over the past month, many times did you most typically get up to urinate from the time you went to bed until the time you got up in the morning?					

Psychosocial History and Stress

Are you currently married?

○ Yes ◉ No

Have you been married previously?

○ Yes ◉ No

What is your current occupation?

How many hours do you work per week?

Do you work shifts?

○ Yes ◉ No

What occupations have you had in the past?

How many weeks of vacation do you take each year?

Number of close friends:

Describe any stressful events in the previous year (e.g. death, separation, financial stress, legal concerns, occupational stress, school or other):

Are you a member of a social or religious organization?
○ Yes ◉ No

Name/s of organization/s:

Number of people living in your household:

How many hours of sleep per night do you average?

Do you participate in stress management programs (e.g. yoga, meditation, music)?
○ Yes ◉ No

Risk Factors

Tobacco Usage:
◉ I have never smoked ○ I used to smoke ○ I currently smoke

Amount of Smoking:

	Less than 1 package per day	1-2 packages per day	2-3 packages per day	3 or more packages per day
I used to smoke	○	○	○	○
I currently smoke	○	○	○	○

Alcohol Consumption:
◉ I don't drink at all ○ I currently drink
○ I used to drink

Number of years since you drank:

What other alcohol do you currently drink and how much per day?

Number of glasses of wine you currently drink per day:

Risk Behavior - Driving Risk Behavior

Do you wear a seat belt (as a passenger or driver)?
◉ Always ○ Sometimes ○ Never

Drinking and Driving: Do you drive while over the legal limit?
◉ Often ○ Sometimes ○ Never

Have you ridden with a driver who is over the legal limit?
◉ Often ○ Sometimes ○ Never

What type of vehicle do you drive?
◉ Compact Car ○ Mid-size Car ○ Large Car ○ Van ○ Truck ○ Motorcycle

How many minutes per day is your commute?

How many accidents have you been involved in during the last five years?

Other Risk Behavior: Do you suntan?

◉ Often ○ Sometimes ○ Never

Do you have unprotected sex?

◉ Always ○ Sometimes ○ Never ○ Currently ○ Previously

How many sexual partners have you had in your lifetime?

◉ 1 ○ 2-10 ○ 10-20 ○ 20-30 ○ 30+

Do you have smoke alarms and/or sprinklers in your home?

○ Yes ◉ No

Do you own a gun?

○ Yes ◉ No

Is it stored unloaded and locked?

○ Yes ◉ No

Do you wear protective gear or a helmet for sports?

○ Yes ◉ No

AGHDA-QoL Questionnaire

Quality of Life Assessment of Growth Hormone Deficiency in Adults

The AGHDA Questionnaire asks you to answer 'yes' or 'no' to the following statements. Each 'yes' scores 1 point; the higher the score, the worse the quality of life.

	Yes	No
I have to struggle to finish jobs	○	○
I feel a strong need to sleep during the day	○	○
I often feel lonely even when I am with other people	○	○
I have to read things several times before they sink in	○	○
It is difficult for me to make friends	○	○
It takes a lot of effort for me to do simple tasks	○	○
I have difficulty controlling my emotions	○	○
I often lose track of what I want to say	○	○
I lack confidence	○	○
I have to push myself to do things	○	○
I often feel very tense	○	○

I feel as if I let people down	○	○
I find it hard to mix with people	○	○
I feel worn out even when I've not done anything	○	○
There are times when I feel very low	○	○
I avoid responsibilities if possible	○	○
I avoid mixing with people I don't know well	○	○
I feel as if I am a burden to people	○	○
I often forget what people have said to me	○	○
I find it difficult to plan ahead	○	○
I am easily irritated by other people	○	○
I often feel too tired to do the things I ought to do	○	○
My memory lets me down	○	○

If your current condition were to last the rest of your life, how much would it bother you?

◉ Not at all ○ Somewhat ○ More than I would be comfortable with ○ It would be terrible

Depression (PHQ-9)

Rate from 0-4: Over the last 2 weeks, how much have you been bothered by any of the following problems?

	0	1	2	3	4
Little interest or pleasure in doing things:	○	○	○	○	○
Feeling down, depressed, or hopeless:	○	○	○	○	○
Trouble falling/staying asleep, sleeping too much:	○	○	○	○	○
Feeling tired or having little energy:	○	○	○	○	○
Poor appetite or overeating:	○	○	○	○	○
Feeling bad about yourself, or that you are a failure, or have let yourself or your family down:	○	○	○	○	○
Having trouble concentrating, such as reading a newspaper or watching TV:	○	○	○	○	○
Moving or speaking so slowly that other people could have noticed. Or the opposite; being fidgety or restless, moving around more than usual:	○	○	○	○	○
Thoughts that you would be better off dead or of hurting yourself in some way:	○	○	○	○	○

Do you see a counselor?

○ Yes ◉ No

If you checked off any problem on the above questions, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

◉ Not difficult at all ○ Somewhat difficult ○ Very difficult ○ Extremely difficult

Anxiety (GAD-7)

Rate from 0-4: Over the last 2 weeks, how much have you been bothered by any of the following problems?

	0	1	2	3	4
Feeling nervous, anxious or on edge	○	○	○	○	○
Not being able to stop or control worrying	○	○	○	○	○
Worrying too much about different things	○	○	○	○	○
Trouble relaxing	○	○	○	○	○
Being so restless that it is hard to sit still	○	○	○	○	○
Becoming easily annoyed or irritable	○	○	○	○	○
Feeling afraid as if something awful might happen	○	○	○	○	○

If you checked off any problem/s on the above questions, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

◉ Not difficult at all ○ Somewhat difficult ○ Very difficult ○ Extremely difficult

Epworth Sleepiness Scale

Rate from 0-4 how often you become sleeping during these activites:

	1	2	3	4	5
Sitting and reading	○	○	○	○	○
Sitting inactive in a public place (e.g a theater or a meeting)	○	○	○	○	○
Watching TV	○	○	○	○	○
As a passenger in a car for an hour without a break	○	○	○	○	○
Lying down to rest in the afternoon when circumstances permit	○	○	○	○	○
Sitting and talking to someone	○	○	○	○	○
Sitting quietly after a lunch without alcohol	○	○	○	○	○
In a car, while stopped for a few minutes in traffic	○	○	○	○	○

If you have blood test results from the past 6 months, please upload them here:

Upload or drag files here.

Diet Log:

Please provide a complete record of your dietary intake (ideally, for one week)

Date:

Breakfast #1:

Lunch:

Dinner:

Snacks:

Date:

Breakfast #2:

Lunch:

Dinner:

Snacks:

Date:

Breakfast #3:

Lunch:

Date:

Dinner:

Snacks:

Breakfast #4:

Date:

Lunch:

Dinner:

Snacks:

Date:

Breakfast #5:

Lunch:

Dinner:

Date:

Snacks:

Breakfast #6:

Lunch:

Date:

Dinner:

Snacks:

Breakfast #7:

Date:

Lunch:

Dinner:

Snacks:

Date:

Time:

Food:

Amount:

Date:

Time:

Food:

Amount:

Date:

Time:

Food:

Amount:

Date:

Today's date:

Signature