



## Male General Health Questionnaire

These questions have been designed to give a clear picture of your present health status and to identify any potential health problems for the future. All your answers are confidential and will only be seen by the health assessor. However, should a significant health problem be detected requiring medical investigation, you will be given a letter to take to your GP.

You should receive a summary within seven to ten days of your assessment. If you give your e-mail address, your summary will be sent electronically.

**Name:**

**Date of Birth:**

**Address:**

**Tel No:**

**E-mail:**

**GP Name & Address:**

**Occupation:**

**Hours of work per week:**

### Personal Medical History

*Please put  for YES and  for NO. Leave blank if unsure.  
If you answer YES, please give brief details in Supplementary Information section.*

**1) Do you or have you ever suffered from any of the following cardiovascular diseases or disorders?**

Heart Attack

Angina

Recurrent Chest Pain

Palpitations

High Blood Pressure

Heart Murmur

Rheumatic

Irregular Pulse

Valve Disease

**2) Do you or have you ever suffered from any of the following diseases or disorders of the brain?**

Stroke

Dizziness

Epilepsy

Convulsions

**3) Do you or have you ever suffered from any of the following nervous disorders?**

Anxiety

Depression

Stress

**4) Do you or have you ever suffered from any of the following respiratory diseases or disorders?**

Asthma                      Chronic Bronchitis                      Tuberculosis                      Coughing Up Blood

                                                                

**5) Do you or have you ever suffered from any disease or disorder of the following genito-urinary organs?**

Kidneys                      Bladder (eg cystitis)

                    

**6) Do you or have you ever suffered from any of the following diseases or disorders of the digestive system?**

Peptic Ulcer                      Recurrent Diarrhoea                      Recurrent Constipation                      Rectal Bleeding

                                                                

Ulcerative Colitis                      Crohn's Disease                      Irritable Bowel Syndrome

                                          

**7) Do you or have you ever suffered from any of the following liver disorders?**

Jaundice                      Hepatitis                      Cirrhosis

                                          

**8) Do you or have you ever suffered from any of the following diseases or disorders of the muscles or joints?**

Slipped Disc                      Osteoarthritis                      Rheumatoid Arthritis                      Gout

                                                                

**9) Do you or have you ever suffered from any of the following endocrine conditions?**

Diabetes Type 1                      Diabetes Type 2                      Glandular Disease                      Thyroid Disorder

                                                                

**10) Do you or have you ever suffered from any disease or disorder of the following?**

Skin                      Eyes                      Ears                      Nose                      Throat                      Mouth

                                                                                                            

**11) Have you ever been diagnosed as having any form of the following?**

Cancer                      Tumour                      Cyst                      Lump

                                                                

If yes, where in the body? .....

12) Have you ever suffered from any of the following blood disorders?

Anaemia

Leukaemia

13) Do you suffer from any of the following progressive debilitating diseases?

Multiple Sclerosis

Parkinson's Disease

Muscular Dystrophy

14) Have you ever undergone any of the following investigations (excluding pregnancy)?

Xray

ECG

CT Scan

MRI Scan

Ultrasound

Blood Test

15) Have you ever undergone a surgical operation?  If yes, give details below

16) Have you ever suffered from any serious injury requiring hospital treatment?

17) Have you ever received treatment from a Complementary Health Practitioner?

<b>Supplementary Information</b>	
<i>Please insert question number and relevant details in the space provided</i>	
Question Number	Brief Details ie. condition, dates, investigations, duration of treatment etc

**Genito-Urinary History**

Do you routinely examine your testicles for lumps ?

Have you ever noticed a lump?  If yes, did you seek medical advice?

What was the outcome? .....

Do you need to pass urine during the night?  Rarely  Occasionally  Regularly

How often during the night do you need to get up to pass urine?

Do you sometimes have difficulty passing urine?

Have you ever noticed blood in your urine?

If you are over 50, has your GP ever checked your prostate gland?

Have you ever had a blood test for Prostate Specific Antigen (PSA)?

Do you ever suffer from erectile dysfunction (impotence)?

If yes, have you received treatment for this?

Have you ever had a bone density scan to detect osteoporosis?

If yes, was the result above or below the expected level for your age?

**Medication: Please state the medicines you are currently taking**

Name of Medicine	Dosage	Times taken per day
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

**Nutritional or Herbal Supplements: Please state any you are currently taking**

Name of Supplement	Dosage	Times taken per day
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

**Allergies or Intolerances:**

Do you suffer from any allergies?

If yes, what are you allergic to? .....

Has your allergy been confirmed by a specialist or test?

Do you suffer from any food intolerances?

If yes, what are you intolerant to? .....

Has your intolerance been confirmed by a specialist or test?

**Smoking Status:**

Do you smoke?  If yes, please state  Cigarettes  Cigars  Pipe  Other

How many a day?  Do you intend to give up smoking soon?

If you do not smoke now, have you ever smoked?

If yes, please state  Cigarettes  Cigars  Pipe  Other

When did you stop smoking?

**Alcohol Status:**

*One unit = 1/2 pint of Beer/Cider, a small glass of wine, or a pub measure of spirits*

What is your average weekly consumption of alcohol in units?

If <1, how many units a month?  Did you regularly drink more in the past?

Do you drink more than 3 units a day?  Never  Occasionally  x1/week or more  Every Day

**Dietary History:**Do you eat at least 3 meals a day? 

If not, which meal(s) do you miss? .....

Do you eat at least 5 portions of fruit and vegetables a day? Do you eat meat ?  Do you eat fish?  Are you a Vegetarian/Vegan? Do you include roughage (high fibre foods) in your diet? Do you eat convenience/processed food and takeaways? If yes, how often?    

&lt;1 a week

1-2 x a week

3-6 x a week

Every day

Regularly

Occasionally

Never

Do you eat organic produce?   Do you usually add sugar to beverages or breakfast cereals? Do you use artificial sweeteners?  If so, which brand? .....How many glasses of water do you drink a day?  Do you drink tap water? Is your water fluoridated?  Do you use a water filter? How many glasses of fruit juice do you drink a day? Do you drink caffeinated tea or coffee?  No. of cups of tea  Cups of coffee Do you drink fizzy drinks?  How many a week?  Do you drink diet versions? **Exercise:**Do you have a regular exercise routine? Do you do at least ½ hour of brisk exercise five times a week? 

If not, how much exercise do you do in a week? .....

What type(s) of exercise/activity do you do? .....

Do you have a sedentary job? Do you often drive short distances rather than walk? Do you normally take the lift or escalator rather than the stairs? Do you have a disability that prevents you from exercising? Do you find time to relax each day?

**Dental History:**

When did you last visit a dentist?

Do you have mercury fillings?

Do you suffer from mouth ulcers?  If yes, how often?  Occasionally  Regularly

Do you use a toothpaste containing fluoride?

Do you use a mouthwash containing alcohol?

**Chemical Exposure:**

Do your toiletries contain any of the following ingredients?

Sodium Lauryl Sulphate	Sodium Laureth Sulphate	Propylene Glycol	DEA / TEA / MEA
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Talc	Isopropyl	DMDM hydantoin	Imidazolidinyl urea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Aluminium	Butylated hydroxytoluene
		<input type="checkbox"/>	<input type="checkbox"/>

Do you use air fresheners (any type)?

Do you use supermarket or main brands of household cleaning products?

**Family History:**

Have close members of your family suffered from any of the following diseases or disorders?  
Please put **M** for mother, **F** for father, **S** for sister or **B** for brother.

Diabetes Type 1 (Insulin dependent)  Diabetes Type 2 (Non-Insulin dependent)

Stroke  Heart Attack  High Blood Pressure  High Cholesterol

Osteo-arthritis  Rheumatoid Arthritis  Osteoporosis

Alzheimer's Disease  Kidney Disease  Respiratory Disease

Glaucoma  Cancer  If yes, where is/was the cancer? .....

Are both your parents still alive?  If no, what age did they die? **M** ..... **F** .....

What caused their death?

**M** .....

**F** .....

