

Men's Confidential Health History

Please type or print clearly

Name: _____

Address: _____

Email address: _____ How often do you check email? _____

Telephone – Work: _____ Home: _____ Cell: _____

Age: _____ Height: _____ Date of Birth: _____ Place of Birth: _____

Current weight: _____ Weight six months ago: _____ One year ago: _____

Would you like your weight to be different? _____ If so, what? _____

Relationship status: _____ Children? _____

Occupation: _____ Hours of work per week: _____

Do you sleep well? _____ How many hours? _____ Do you wake up at night? _____

Why? _____

Generally, what are your stress levels like?: _____ Main stressor? _____

What is your chief concern?: _____

Other concerns? *Think from "head to toe."* _____

Reproductive concerns? _____



adapted from Integrative Nutrition

Any serious illness/hospitalizations/injuries? _____

How is the health of your mother? _____

How is the health of your father? _____

What is your ancestry? _____ What blood type are you? _____

Any pain, stiffness or swelling? _____

Bloating/Constipation/
Diarrhea/Gas? _____ Explain & include no. of
bowel movements/day: _____

Do you take any supplements or medications? Please list: _____

Any healers, helpers, pets or therapies with which you are involved? Please list: _____

What role do sports and exercise play in your life? _____

What do you do (or like to do) for fun? _____

What percentage of your food is home cooked? _____ What percentage is not? _____

Where do you get the rest from? _____

Do you crave sugar, coffee, cigarettes, or have any major addictions? _____

What foods did you eat often as a child?

Breakfast

Lunch

Dinner

Snacks

Liquids

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What about one year ago?

Breakfast

Lunch

Dinner

Snacks

Liquids

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What's your food like these days?

Breakfast

Lunch

Dinner

Snacks

Liquids

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Is there anything else you would like to share today?
