

**La Bella Vita Health and  
Wellness**

10810 E. Via Linda, Suite 113  
Scottsdale, AZ 85259  
Phone: (480) 391-9999  
Fax: (408) 391-9940

**MALE MEDICAL HISTORY**

Welcome to our office. To better help us evaluate you, please complete the following form. If you have any questions, we will be happy to help you. Thank you.

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Occupation \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Email \_\_\_\_\_

**How did you hear about us? Please be specific.**

Friend/Family \_\_\_\_\_

Radio-What station where you listening to? \_\_\_\_\_

Physician Office \_\_\_\_\_

Print Ad- Where was the ad? \_\_\_\_\_

Internet- Which Web site? \_\_\_\_\_

TV- What station were you watching? \_\_\_\_\_

**What procedures are you interested in?**

\_\_\_\_\_ Weight Loss Program

\_\_\_\_\_ Hormone Replacement

Spouse's Name \_\_\_\_\_ Number of Children \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Primary Physician \_\_\_\_\_ City \_\_\_\_\_

List any allergies (and approx. date)

\_\_\_\_\_

List all surgeries (and approximate date)

\_\_\_\_\_

List any medical conditions you are being treated for at this time: \_\_\_\_\_

\_\_\_\_\_

List all medications you are taking: \_\_\_\_\_

\_\_\_\_\_

Do you use: (circle) tobacco alcohol caffeine

**FAMILY HISTORY**

**EXERCISE**

	Diabetes	Heart	Kidney	Cancer	Little to none: _____
Mother	_____	_____	_____	_____	2-3 times/wk: _____
Father	_____	_____	_____	_____	Daily: _____
Brother's	_____	_____	_____	_____	Cardio: _____

Last prostate exam \_\_\_\_\_

**Please put a check mark next to any of the following problems you notice in yourself:**

- |  |   |
|--|---|
| <input type="checkbox"/> Loss of muscle size                 | <input type="checkbox"/> Decline in sex drive               |
| <input type="checkbox"/> Increased fat around waist          | <input type="checkbox"/> Decreased body hair                |
| <input type="checkbox"/> Loss of energy                      | <input type="checkbox"/> Irritable much of the time         |
| <input type="checkbox"/> Lack of motivation                  | <input type="checkbox"/> Poor sense of well-being           |
| <input type="checkbox"/> Lack of aggressiveness e.g. at work | <input type="checkbox"/> Loss of initiative                 |
| <input type="checkbox"/> Loss of interest in hobbies etc.    | <input type="checkbox"/> Inability to concentrate           |
| <input type="checkbox"/> Diminished stamina/endurance        | <input type="checkbox"/> Erection difficulties              |
| <input type="checkbox"/> Bone loss/osteoporosis              | <input type="checkbox"/> Focusing on retirement prematurely |
| <input type="checkbox"/> Grumpier overall                    | <input type="checkbox"/> Less patient                       |
| <input type="checkbox"/> Prostate enlargement                | <input type="checkbox"/> Frequent nighttime urination       |

On a scale of 1 – 10 (10 being severe), what are your stress levels like? \_\_\_\_\_

How long have they been at that level? \_\_\_\_\_

Have you ever had a severely stressful event that affected your well being? Yes No

When you gain weight, where do you gain it? \_\_\_\_\_

Do you have a difficult time getting out of bed in the morning? Yes No

**Which describes your sleeping patterns best (circle one):**

1. I sleep well and awake refreshed.
2. I have a hard time falling asleep, but once I do, I sleep through the night.
3. I fall asleep easily, but wake up during the night and can't go back to sleep easily.
4. Hard time falling asleep AND wake up and can't go back to sleep without difficulty.

Do you get sick easily and often?      Yes      No

Which do you crave? (Circle)    salty foods    sugary foods    fatty foods?

Do you ever get dizzy or lightheaded momentarily when getting up too fast?      Yes      No

Are you an "emotional eater"?      Yes      No

How long has it been since you really felt well? \_\_\_\_\_

What are your two major health complaints?

1. \_\_\_\_\_

2. \_\_\_\_\_