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Men's Health Assessment:

Please answer the following to the best of your ability.
We appreciate your responses in creating a complete, holistic health assessment.

Place a "C" *in front of* all that applies to your CURRENT state of health
Place a "P" *in front of* all that applies to your PAST health history

___Sleep disturbances/Insomnia ___Upper back pain ___Lower back pain ___Shoulder pain ___Neck pain
___Elbow pain ___Wrist/hand pain ___Ankle/foot pain ___Headaches ____Hip pain ___ Rib pain ___Chronic body pain
___Knee pain ___High stress ____Depression/Anxiety ___Dry eyes ___Dry skin/hair ___ Dry throat ___Hernia(s)
___Thinning hair ___Poor vision ___Anemia ___Digestive complaints ___Nausea ___Constipation ___Diarrhea
___History of surgeries ___History of major illness(es) ___Frequent urination ___Scanty urination ___Crave sweets/salty
___Blood in urine ___Frequent UTI ___Low appetite ___Shortness of breath ____Asthma ___High BP ____Palpitations
___High cholesterol ___Ear ringing ____Poor hearing ___Dizziness ___Chest pain/tightness ___Thyroid disorder
___Night sweats ___Day sweats ___ Low libido ___Excessive hunger/thirst ___BPH ___Infertility ___Fatigue/energy crashes
___Abnormal PSA ___Skin conditions ___STD ___Gallstones ___Erectile dysfunction ____Varicocele ___Testicular trauma
___Testicular infection ___Allergies ___Asthma ___Cold hands & feet ___Chronic infections ___Frequent nightmares
___Tendency to feel too warm/hot ___Fatigue/low energy ___Irritability/rage ____Frequent colds/flues

***Please briefly list ANY MAJOR MEDICAL EVENTS: surgeries, illnesses with Age/Date at which it (they) occurred on this form. If there is not enough space, please continue the list on the back of the form.**

***Please briefly describe your vision of optimal health:**

*Are you interested in taking herbs/supplements? **Y/ N**

*Are you interested in receiving seasonal newsletters/coupons/email specials? **Y/ N**