Male General Health Questionnaire

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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.

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
☐	☐	☐

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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? .....

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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? ☐

Supplementary Information

Please insert question number and relevant details in the space provided

Question Number	Brief Details ie. condition, dates, investigations, duration of treatment etc

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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? .....

Rarely Occasionally Regularly

Do you need to pass urine during the night? ☐ ☐ ☐

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
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

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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 = ½ 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 ☐

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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? ☐

	<1 a week	1-2 x a week	3-6 x a week	Every day
If yes, how often?	☐	☐	☐	☐

	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? .....

Do you consume dairy products? ☐ Do you eat margarine? ☐ 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? ☐

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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 ☐

Talc ☐ Isopropyl ☐ DMDM hydantoin ☐ Imidazolidinyl urea ☐ Aluminium ☐ Butylated hydroxytoluene ☐

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 .....

.....

Physical Assessment:

Details to be entered by Nurse Consultant

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Urinalysis: **Albumin** ☐ **Glucose** ☐ **Blood** ☐ **pH** ☐

Height: ..... **Weight:** ..... **Wrist Measurement:** .....

Frame Size: Small / Medium / Large **Body Mass Index:** .....

Waist: ..... **Hip:** ..... **Waist/Hip Ratio (W H):** .....

Blood Pressure: ..... **2nd Reading if >140/90:** .....

Pulse Pressure: ..... **Pulse:** ..... **Regular/Irregular:** .....

PulmoLife Readings

1) FEV1 ..... **Percentage:** ..... **Pulmonary Age:** .....

Peak Flow: 1) ..... 2) ..... 3) .....

CardioCheck Readings

1) PPT .....ms; **RI** .....%; **SI Normal Range** .....; **SI** .....m/s; **VA** .....

2) PPT .....ms; **RI** .....%; **SI Normal Range** .....; **SI** .....m/s; **VA** .....

Recommendations:

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