

IMPORTANT: BODY TEMPERATURE MEASUREMENT.

If time permits, Please take your body temperature using an oral thermometer on 5 separate mornings and record below. Do the measurement just after waking (prior to any food or drink). They do not need to be on consecutive mornings.

| <u>DAY 1</u> | <u>DAY 2</u> | <u>DAY 3</u> | <u>DAY 4</u> | <u>DAY 5</u> |
|--|--------------|--------------|--------------|--------------|
| Have you had a vasectomy? No <input type="checkbox"/> Yes <input type="checkbox"/> Date: _____ | | | | |

Have you had a bone densitometry to check for Osteoporosis? No Yes Date: _____

Result of last densitometry: _____

List any surgical operations you have had in your life:

List any medical illnesses you have had in your life:

List any family history of illnesses, in particular prostate cancer:

List any major stress events in your life (e.g. the death of someone close to you, divorce, etc):

What are your current work and life activities? (e.g. job, home activities, hobbies)

List any hormone replacement therapy you have had:

List any medications you are currently taking:

List any supplements you are currently taking:

List the things you do for exercise each week. (If your job is physically demanding include this too):

If you have been / are a current smoker please complete the following details

Began smoking: _____

Quit smoking between: _____ and _____

_____ and _____

_____ and _____

_____ and _____

Quit smoking successfully: _____

Still smoking? Please list the amount of cigarettes per day: _____

Fluid amounts per day

Coke / Pepsi / other caffeinated soft drinks: _____

Other soft drinks: _____

Milk: _____

Water: _____

Coffee: _____

Tea: _____

Alcohol: _____

Dietary History

State what are the most common things you would eat with each meal

Breakfast: _____

Mid morning: _____

Lunch: _____

Mid afternoon: _____

Dinner: _____

After Dinner: _____

Snacks: _____

Shade in all areas of pain - include headaches and any other pain anywhere in the body

