



Dr. Shel
WELLNESS & MEDICAL SPA

Men's Consultation

Date: _____ Referral: _____ Email: _____
Name: _____ Home: _____ Cell: _____
Address: _____ City: _____ State: _____ Zip: _____
DOB: _____ AGE: _____ Martial Status: M W D S Occupation: _____
Reason for Visit: _____

Please check all applicable and explain:

- | | | |
|---|--|--|
| <input type="checkbox"/> Excessive Weight | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mental Health/Depression |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Elevated Cholesterol <input type="checkbox"/> |
| Hypothyroidism | <input type="checkbox"/> Seizures | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Elevated Triglycerides | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sleep Disorders |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Irrit. Bowel Syndrome | <input type="checkbox"/> Skin Complaints |

Health Maintenance: (Date last Exam)

Bone Density: _____ Physical Exam: _____ PSA: _____

Lipid Profile: _____ Flex Sigmoidoscopy _____

Td: _____ Influenza: _____ Pnuemovax: _____

Medical Problems: (Explained from above) _____

Name and number of Primary Care Physician: _____

Current Medications/Supplements: _____

Do you have any drug allergies? No Yes If Yes explain: _____

Do you exercise? No Yes What kind? _____ How Often _____

Do you smoke? No Yes How much? _____ How Long? _____

Do you use alcohol? No Yes How much? _____ How Long? _____

Have you had a major illness/hospitalization/surgery? No Yes

Explain: _____

Is there a family history of: (Please check)

- | | | | |
|--|--|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Prostate Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Other _____ | |

Are you interested in our other services?

- | | | |
|--|--|--|
| <input type="checkbox"/> Nutritional testing | <input type="checkbox"/> Laser Rejuvenation | <input type="checkbox"/> Weight Management |
| <input type="checkbox"/> Allergy Testing | <input type="checkbox"/> Laser Hair Removal | <input type="checkbox"/> Massage |
| <input type="checkbox"/> Weight Management | <input type="checkbox"/> Laser Skin Tightening | <input type="checkbox"/> Laser Hair Regrowth |

Family History

	Medical Problem(s)	
Father- alive or deceased?	Age	_____
Mother- alive or deceased?	Age	_____
Brothers/sisters:		Medical Problem(s)
_____	Age	_____
_____	Age	_____
_____	Age	_____

REVIEW OF SYMPTOMS

Heart

- Y N** Do you ever feel your heart skip a beat? How often? _____
For how many years? _____
- Y N** Do you have chest pain? How often? _____
For how many years? _____
Is the pain sharp / stabbing / dull / aching? _____ Does it radiate to your neck, back, or shoulders?
- Y N** How long does the pain last? _____
- Y N** Do you feel like you are going to pass out?

Gastrointestinal System

- Y N** Do you have abdominal cramping, bloating, excessive belching or intestinal gas?
How often? _____ x/week _____ How long? _____

Urinary Tract

- Y N** Have you ever had bladder infections / kidney infections?
How many x/year? _____ For how many years? _____
- Y N** Have you ever had kidney stones? How many times? _____
Year of last episode _____
- Y N** Do you have burning upon urination?
- Y N** Do you have increased frequency of urination?

Skin

- Y N** Do you have any unexplained skin rashes or itchy skin?
How long? _____ months _____ years
Do you know the cause of your rashes/itchy skin? _____

Thyroid

- Y N** Have you been diagnosed with a thyroid disorder? Year diagnosed _____
- Y N** Were you diagnosed with hyperthyroidism _____
- Y N** Were you diagnosed with hypothyroidism _____
- Y N** Did you ever take thyroid medication? What year did you quit? _____
Name of medicine _____ Dose _____ mg

Malaise/Fatigue

- Y N** Do you feel you should have more energy?
What is your average energy level on a scale of 0 to 10 with 10 meaning brimming with energy and 1 or 2 meaning the inability to get out of bed?
ENERGY LEVEL 0-10 _____ /10 For how many years? _____

Hair Condition

- Y N** Do you have coarse or fine hair? For how many years? _____
- Y N** Have you ever had significant hair loss?
How long? _____ months _____ years

Weight

- Y N** Have you had significant weight gain? How many pounds? _____
Since what year? _____
- Y N** Do you have difficulty losing weight? How long? _____

Mood

- Y N** Do you ever feel discouraged, blue or depressed more than 10% of the time?
What percent of the time? _____ % For how many years? _____
- Y N** Have you ever taken anti-depressants?
Which one(s)? _____
Between what ages? _____ y.o. and _____ y.o.

Skin

- Y N** Do you have dry skin? For how many years? _____

Sleep

- Y N** Do you have insomnia or restless sleep? How many years? _____
- Y N** Do feel tired after a full night's sleep? How many years? _____
- Y N** Do you have afternoon fatigue?
How many hours of sleep do you require? _____ hours/night?

Dr. Shel's Weight Loss Questionnaire

What are your weight loss goals?

What weight loss methods have you tried previously?

How much weight did you lose? Are you happy with the results?

Please list your food intake on a typical day

	Breakfast	Snack	Lunch	Snack	Dinner
Time					
Foods					
Calories					

Please list your exercise routine for a typical week. Please list duration under each day.

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Cardio							
Weights							
Pilates							
Yoga							
Other							

Yeast Overgrowth Questionnaire

This Yeast Questionnaire lists symptoms and other factors most commonly found in people suffering from Yeast Overgrowth. Read each question carefully and total the number that applies to you.

Do you have fatigue?	3
Do you feel lethargic?	2
Do you have recurrent vaginal yeast infections?	4
Have you taken antibiotics multiple times during your life?	3
Do you have abdominal bloating, cramping or gas?	3
Do you have indigestion or heartburn?	2
Do you have abnormal bodily reactions to wine, beer or alcoholic beverages, such as flushing, headache, sinus congestion or itchy skin?	2
Do you crave sugar or bread products?	2
Do you have difficulty concentrating?	1
Do you have depressed moods?	1
Do you develop skin rashes or hives?	2
Do you have athlete's foot?	4
Do you have jock itch?	4
Do you have rectal itching?	3
Do you have fungal infections under the toenails or fingernails?	3
Do you have allergy symptoms?	1
Do you have recurrent respiratory infections?	1
Do you have joint pain?	1
Do you have muscle pain?	1

Total: _____

- * < 10 — It is not likely that you have yeast overgrowth.
- * 10-16 — Yeast overgrowth is a possibility.
- * > 16 — Yeast overgrowth is very likely.

Low Thyroid Function

This Thyroid Questionnaire lists symptoms and other factors most commonly found in people suffering from low thyroid, or hypothyroidism. Read each question carefully and total the number that applies to you.

Do you have fatigue?	4
Do you have elevated cholesterol?	4
Do you have difficulty losing weight?	2
Do you have cold hands and feet?	2
Are you sensitive to the cold?	2
2Do you have difficulty thinking?	2
Do you find it hard to concentrate?	2
Do you experience brain fog?	2
Do you have poor short term memory?	2
Do you have depressed moods?	2
Are you experiencing hair loss?	2
Do you have less than one bowel movement a day?	2
Do you have dry skin?	2
Does your skin itch in the winter?	1
Do you have fluid retention?	2
Do you have recurrent headaches?	1
Do you sleep restlessly?	1
Are you tired when you awaken?	2
Do you have afternoon fatigue?	2
Do you experience tingling or numbness in your hands or feet?	2
Do you have decreased sweating?	2
Have you had problems with infertility or miscarriages?	2
Do you have recurrent infections?	2
Do your muscles ache?	2
Do you have joint pain?	2
Do you have thinning of your eyebrows or eyelashes?	2
Is your tongue enlarged with teeth indentations?	2
Is your skin pasty, puffy or pale?	2
Do you have decreased body hair?	2
Is your voice hoarse?	1
Do you have a slow pulse?	2
Do you have low blood pressure?	2
Does your body temperature run below the normal 98.6°?	4
Do you have sleep apnea?	2

Total: _____

- * < 9 — It is not likely that you have low thyroid function.
- * 9-28 — Low thyroid function is a possibility.
- * > 28 — Low thyroid function is very likely.

Low Testosterone Levels

This questionnaire lists symptoms and other factors most commonly found in men suffering from low testosterone. Read each question carefully and check the box if it applies to you.

Do you have fatigue?	2
Do you have a lack of drive?	3
Do you lack initiative?	3
Are you less assertive?	3
Do you have a decline in your sense of well being?	2
Do you have depressed moods?	2
Are you frequently irritable?	2
Has your self-confidence declined?	2
Do you find it difficult to set goals?	2
Do you have a difficult time making decisions?	2
Have you had a decline in your mental sharpness?	2
Has your stamina and endurance lessened?	2
Have you lost muscle mass, strength or tone?	4
Have you gained body fat around your waist?	2
Do you have elevated triglycerides?	2
Do you have elevated cholesterol?	4
Has your libido decreased?	2
Has your sexual ability declined?	2
Is it difficult to obtain or maintain an erection?	2

Total _____

- * < 7 — It is not likely that you have low testosterone.
- * 7-20 — Low testosterone is a possibility.
- * > 20 — Low testosterone is very likely.

Adrenal Fatigue

This Adrenal Fatigue Questionnaire lists symptoms and other factors most commonly found in people suffering from adrenal fatigue. Read each question carefully and check the box if it applies to you.

Do you have fatigue?	3
Do you have allergies?	3
Do you have asthma?	3
Do you have recurrent infections?	3
Are you under severe emotional stress?	3
Do you suffer from chronic pain or physical stress?	3
Do you have low blood pressure?	2
Do you have a low pulse rate (less than 70 bpm with no exercise)?	2
When you rise quickly, do you feel as though you might pass out?	2
Do you have depressed moods?	2
Do you have joint pain?	2
Do you have muscle pain?	2
Do you have low libido?	2
Do you have hair loss?	2
Do you have anxiety attacks?	2

Total Score: _____

- * < 7 — It is not likely that you have adrenal fatigue.
- * 7-12 — Adrenal fatigue is a possibility.
- * > 12 — Adrenal fatigue is very likely.

Allergies

This Allergy Questionnaire lists symptoms and other factors most commonly found in people suffering from some form of allergy.

Do you have fatigue?	3
Do you have frequent headaches?	2
Do you have sneezing, post nasal drainage or itching of the nose?	4
Do you have frequent colds?	2
Do you experience dizziness?	4
Do you get sinus infections every year?	1
Do your eyes itch, water, get red or swell?	4
Do you have recurrent ear infections?	2
Do you have asthma, wheezing, tightness in the chest or chronic cough?	4
Do you have skin problems such as eczema, skin rashes, itching or hives?	3
Do you have indigestion, bloating, diarrhea or constipation?	1
Do your symptoms worsen during a particular season, such as the spring or fall?	4
Do your symptoms change when you go indoors or outdoors?	3
Are your symptoms worse in parks or grassy areas?	4
Are your symptoms worse in the bedroom after going to bed, or in the morning upon arising?	2
Do you awaken in the middle of the night with congestion?	2
Are your symptoms worse when you come into contact with dust?	4
Are your symptoms worse around animals?	2
Do you have any blood relatives with allergies?	2
Do you have mood swings or feel depressed for no reason?	1
Do you have recurrent yeast infections, jock itch, Athlete's foot or fungus under your toenails?	2
Do you develop symptoms after eating or drinking certain foods?	2
Do you sometimes feel stimulated, hyperactive or fatigued after meals?	2
Do you have dark circles under your eyes?	2
Do you have a crease across the bridge of your nose?	2
Total	_____

- * < 9 — It is not likely that you have allergies.
- * 9-12 — Possibility of allergies.
- * 13-30 — Allergies are probable.
- * > 30 — Allergies are very likely.

Male Hormone Checklist



Dr. Shel
WELLNESS & MEDICAL SPA

Check applicable symptoms of each category:

Androgen Deficiency

- | | |
|--|--|
| <input type="checkbox"/> Low libido | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Thinning Pubic Hair |
| <input type="checkbox"/> Aches/Pains/Arthritis | <input type="checkbox"/> Decreased Muscle Mass |
| <input type="checkbox"/> Memory Lapses | <input type="checkbox"/> Bone Loss |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Thinning Skin |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Fibromyalgia |

Cortisol Deficiency

- | | |
|---|---|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Cold Body Temp. |
| <input type="checkbox"/> Sugar Cravings | <input type="checkbox"/> Irritable |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Chemical Sensitivity | <input type="checkbox"/> Heart Palpitations |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Aches / Pains |

Thyroid Deficiency

- | | |
|--|---|
| <input type="checkbox"/> Tired or Exhausted | <input type="checkbox"/> Difficult to Concentrate |
| <input type="checkbox"/> Sad or Depressed | <input type="checkbox"/> Mood Changes |
| <input type="checkbox"/> Cold Body Temp. | <input type="checkbox"/> Swelling/Puffy eye/face |
| <input type="checkbox"/> Cold Hands & Feet | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Slow Pulse Rate |
| <input type="checkbox"/> Can't Lose Weight | <input type="checkbox"/> Decreased Sweating |
| <input type="checkbox"/> Memory Lapse | <input type="checkbox"/> Hair Dry/ Brittle |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Hair Loss |
| <input type="checkbox"/> Nails breaking/ Brittle | <input type="checkbox"/> Infertility Problems |
| <input type="checkbox"/> Aches / Pains | <input type="checkbox"/> Slowed Reflexes |
| <input type="checkbox"/> Low Libido | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Heart Palpitation | <input type="checkbox"/> Thick Tongue |
| <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> Slow Ankle Reflex |
| <input type="checkbox"/> Bone Loss | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Decreased Muscle Mass | |
| <input type="checkbox"/> Thinning Skin | |

Androgen Excess

- | | |
|---|--|
| <input type="checkbox"/> Excessive Facial Hair | <input type="checkbox"/> Oily Skin |
| <input type="checkbox"/> Excessive Body Hair | |
| <input type="checkbox"/> Increased Acne | <input type="checkbox"/> Hair Loss scalp |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Nervous/Irritable |
| <input type="checkbox"/> Elevated Triglycerides | |

Cortisol Excess

- | | |
|---|--|
| <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> Heart Palpitation |
| <input type="checkbox"/> Bone Loss | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Weight Gain/Loss | <input type="checkbox"/> Cold Body Temp |
| <input type="checkbox"/> Muscle Mass Loss | <input type="checkbox"/> Sugar Cravings |
| <input type="checkbox"/> Thinning Skin | <input type="checkbox"/> Low Libido |
| <input type="checkbox"/> Elevated Triglycerides | <input type="checkbox"/> Hair Loss |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Increased Facial Hair |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Increased Body Hair |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Memory Lapse | <input type="checkbox"/> Nervous |