

## **Confidential Questionnaire**

## Men's Health Screen

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Birth Date Today's Date

All information given in the questionnaire will remain strictly confidential and will only be divulged to the reporting thermologist and any other practitioner that you specify.

Head & Neck  Do you suffer with headaches?  If yes, ○ once a month or less ○ more than once a month  Do you have known allergies? Food Environmental  Do you have TMJ, or does your jaw click?  Do you currently have a cold?  Are you being treated for a thyroid disorder? Type  Do you have neck pain?  Do you have upper back pain?  Do you have a known history of carotid artery disease?  Do you have a family history of stroke?  Do you currently suffer from sinus problems?	0	Yes	No		
If yes, ○ once a month or less ○ more than once a month  Do you have known allergies? Food Environmental  Do you have TMJ, or does your jaw click?  Do you currently have a cold?  Are you being treated for a thyroid disorder? Type  Do you have neck pain?  Do you have upper back pain?  Do you have a known history of carotid artery disease?  Do you have a family history of stroke?	Ο	0 0 0 0	0 0		
If yes, o once a month or less o more than once a month  2. Do you have known allergies? Food Environmental  3. Do you have TMJ, or does your jaw click?  4. Do you currently have a cold?  5. Are you being treated for a thyroid disorder? Type  6. Do you have neck pain?  7. Do you have upper back pain?  8. Do you have a known history of carotid artery disease?  9. Do you have a family history of stroke?	0	0 0 0 0	0 0		
2. Do you have known allergies? Food Environmental 3. Do you have TMJ, or does your jaw click? 4. Do you currently have a cold? 5. Are you being treated for a thyroid disorder? Type 6. Do you have neck pain? 7. Do you have upper back pain? 8. Do you have a known history of carotid artery disease? 9. Do you have a family history of stroke?	0	0 0 0	0		
B. Do you have TMJ, or does your jaw click?  B. Do you currently have a cold?  C. Are you being treated for a thyroid disorder? Type  Do you have neck pain?  Do you have upper back pain?  Do you have a known history of carotid artery disease?  Do you have a family history of stroke?	0	0 0 0	0		
<ul> <li>Do you currently have a cold?</li> <li>Are you being treated for a thyroid disorder? Type</li> <li>Do you have neck pain?</li> <li>Do you have upper back pain?</li> <li>Do you have a known history of carotid artery disease?</li> <li>Do you have a family history of stroke?</li> </ul>		0 0 0	0		
<ul> <li>5. Are you being treated for a thyroid disorder? Type</li> <li>5. Do you have neck pain?</li> <li>7. Do you have upper back pain?</li> <li>8. Do you have a known history of carotid artery disease?</li> <li>9. Do you have a family history of stroke?</li> </ul>		0	0		
<ul><li>Do you have neck pain?</li><li>Do you have upper back pain?</li><li>Do you have a known history of carotid artery disease?</li><li>Do you have a family history of stroke?</li></ul>		0	_		
<ul><li>7. Do you have upper back pain?</li><li>8. Do you have a known history of carotid artery disease?</li><li>9. Do you have a family history of stroke?</li></ul>			0		
<ul><li>B. Do you have a known history of carotid artery disease?</li><li>Do you have a family history of stroke?</li></ul>		0			
D. Do you have a family history of stroke?			0		
		0	0		
1. Do you currently suffer from sinus problems?	9. Do you have a family history of stroke?				
o. Do you currently suffer from sinus problems?		0	0		
1. Do you have a history of dental problems?		0	0		
Root canals Gum disease Implants					
Non-replaced extractions Dentures					
2. Have you had a dental cleaning in the past 7 days?		0	0		
	,				
o you have any special concerns or are there any details related to the in	ntorma	ition on	ove?		

## Chest, Heart & Lungs

1. Have you been diagnosed with:	,	Yes	No
Heart disease?		0	0
Lung disease?		0	0
Upper spine disc	rders?	0	0
2. Do you suffer with upper back pain?			0
<ul><li>3. Do you suffer with chest pain?</li><li>4. Have you ever had surgery to your:</li></ul>		Ο	Ο
Heart?		0	0
Lungs?		Ο	0
Mid to upper bac	k?	0	0
5. Do you have asthma or shortness of breath?		0	0
		Yes	No
6. Do you currently smoke?		Ο	0
7. Have you smoked in the past 5 years?			0

## Abdomen & Lower Back

_	Yes	No		Yes	No
Do you suffer from acid reflux or other		Have you had surgery or disease i	n the:		
digestive problems?	0	0			
2. Do you suffer pain in the:			Stomach?	0	0
Stomach?	0	0	Spleen(Upper Left)?	0	0
Below R Breast?	0	0	Liver(Upper Right)?	0	0
Below L Breast?	0	0	Kidneys?	0	0
Abdomen?	0	0	Intestines?	0	0
Lower Back?	0	0	Abdomen?	0	0
Pelvic Region?	0	0	Lower Back?	0	0
		<u> </u>	Pelvic Region?	0	0

Have you consumed alcohol in the past 24 hours?	
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Do you have any special concerns or are there any details related to the information above?