PHYSICAL HISTORY FORM

From *Restoring the Pleasure* 2016

Age: _____ Height: _____ Weight: _____

1. HEALTH HISTORY (BIRTH TO PRESENT)

General Description	Illness and Treatments	Surgical Operations
Childhood Adolescence Adulthood		

Were you a bed wetter? Until what age? How was that handled?
(This may keep women from letting go orgasmically; it may cause men to be anxious about letting go, which could lead to premature ejaculation or ED.)

2. CURRENT PHYSICAL HEALTH

General Description	Illness and Treatments	Surgical Operations

Are any of these health issues affecting your sexual functioning? If you aren't certain, determine this with your physician.

Specific Difficulties (Circle any of the following that apply to you; discuss their effects on your sex life with your spouse):

headaches	loss of appetite	depression
dizziness	bowel disturbances	anxiety
fainting spells	fatigue	fears
palpitations	insomnia	suicidal thoughts
stomach trouble	nightmares	alcoholism

Allergies and Special Diet/Food Restrictions:

List medications you are currently taking (check side effects online):

Substance Intake	No	Yes	Frequency	Amount	Type
Tobacco					
Alcohol					
Nonprescription Drugs					
Street Drugs (Now or Previously)					

List other illnesses or difficulties within your family of origin.

3. MENTAL HEALTH

Describe how you usually feel emotionally.

What mental health difficulties have been struggles for you?

Describe diagnoses and treatments.

4. MEDICAL TESTS

If you have been tested for any of the following, please list the results of those tests.

Thyroid function:

Hormonal levels:

Diabetes:

Cardiovascular disease:

Sexually transmitted disease:

Other:

5. REPRODUCTIVE AND SEXUAL HEALTH

Age of first orgasm/ejaculation:

Did this occur . . .

_____ during sleep?

_____ in response to self-stimulation (masturbation)?

_____ in response to pornography?

_____ during sexual play with another person?

Describe any difficulty or infection you have had or now have with your . . .

breasts

genitals

urethra, bladder, or urinary tract

rectum

(female) uterus, cervix, or vagina

(male) prostate gland

How were they treated?

Describe any medical procedure(s) that caused you discomfort as a child or adult.

List any sexually transmitted diseases (STDs) that you have had or currently have.

Genital Disease or STD	Dates of Infection	Treatments and Results

What form(s) of birth control do you use or have you used?

How did/do you respond? (Did you like it? Did it interfere?)

WOMEN

Menstrual History

Age of first period (menses):

What preparation had you received?

What was your reaction to your first period?

Are/were you regular?

Do/did you have pain?

Do/did you experience mood changes (PMS)?

Describe the effect this has/had on your sexual life.

Reproductive History

	Age	Describe	Complications
Pregnancies			
Deliveries			
Miscarriages			
Abortions			
Infertility Struggles			