



### Male Patient Questionnaire & History

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
(Last) (First) (Middle)

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ May we contact you via E-Mail? ( ) YES ( ) NO

In Case of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work: \_\_\_\_\_

Marital Status (check one): ( ) Married ( ) Divorced ( ) Widow ( ) Living with Partner ( ) Single

In the event we cannot contact you by the means you've provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work: \_\_\_\_\_

How did you find us: \_\_\_\_\_

#### Social:

( ) I have used steroids in the past for athletic purposes.

( ) I exercise \_\_\_\_\_ times per week.

#### Habits:

( ) I smoke cigarettes or cigars \_\_\_\_\_ a day.

( ) I drink alcoholic beverages \_\_\_\_\_ per week.

( ) I use caffeine \_\_\_\_\_ a day.



### Medical History

Any known drug allergies: \_\_\_\_\_

Have you ever had any issues with local anesthesia such as lidocaine or epinephrine? ( ) Yes ( ) No

If yes please explain: \_\_\_\_\_

Medications Currently Taking: \_\_\_\_\_

Current Hormone Replacement Therapy: \_\_\_\_\_

Nutritional/Vitamin Supplements: \_\_\_\_\_

Surgeries, list all and when: \_\_\_\_\_

### Medical Illnesses:

- |   |  |
|---|--|
| <input type="checkbox"/> High blood pressure                  | <input type="checkbox"/> Testicular or prostate cancer                             |
| <input type="checkbox"/> High cholesterol                     | <input type="checkbox"/> Elevated PSA  |
| <input type="checkbox"/> Heart Disease                        | <input type="checkbox"/> Prostate enlargement                                      |
| <input type="checkbox"/> Stroke and/or heart attack           | <input type="checkbox"/> Trouble passing urine or take Flomax or Avodart           |
| <input type="checkbox"/> Blood clot and/or a pulmonary emboli | <input type="checkbox"/> Chronic liver disease (hepatitis, fatty liver, cirrhosis) |
| <input type="checkbox"/> Depression/anxiety                   | <input type="checkbox"/> Diabetes  |
| <input type="checkbox"/> Cancer (type): _____                 | <input type="checkbox"/> Thyroid disease   |
|   | <input type="checkbox"/> Arthritis   |

I understand that if I begin testosterone replacement with any testosterone treatment, including testosterone pellets, that I will produce less testosterone from my testicles and if I stop replacement, I may experience a temporary decrease in my testosterone production. I am also aware that testosterone will also decrease my sperm production. This should return to normal 3 months after the pellet or injectable testosterone is out of my system. Testosterone Pellets should be completely out of your system in 12 months.

By beginning treatment, I accept all the risks of therapy stated herein and future risks that might be reported. I understand that higher than normal physiologic levels may be reached to create the necessary hormonal balance.

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Print Name

Signature

Today's Date