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:

( ) High blood pressure
( ) High cholesterol
( ) Heart Disease
( ) Stroke and/or heart attack
( ) Blood clot and/or a pulmonary emboli
( ) Depression/anxiety
( ) Cancer (type): ______________________________

( ) Testicular or prostate cancer
( ) Elevated PSA
( ) Prostate enlargement
( ) Trouble passing urine or take Flomax or Avodart
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis)
( ) Diabetes
( ) Thyroid disease
( ) 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**