



MALE PATIENT INFORMATION

Name: _____ Today's Date: MM/DD/YYYY
 LAST FIRST MIDDLE

Date of Birth: MM/DD/YYYY

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: _____ Cell Phone: _____

Do you have an email address you can share with us: _____

We would like to stay in contact with you at all times. If you have a second residence, please provide us with that information

Street Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____
Employer Address: _____

City: _____ State: _____ Zip Code: _____

Business Telephone: _____

Marital status (please circle): Married Divorced Single Widow Living with Significant Other

In the event we are unable to contact you by the means you've provided above, we would like to have the ability to contact you through your spouse. Please provide the necessary information about your spouse below.

Spouse's Name: _____
 LAST FIRST MIDDLE

Spouse's Date of Birth MM/DD/YYYY

Spouse's Employer: _____

Business Telephone: _____

In case of an emergency, whom should we notify? Contact Name: _____
Contact Information: _____

HOME TELEPHONE CELL PHONE E-MAIL

Relationship: _____

Signature: _____ Date: MM/DD/YYYY



What is the reason for your visit today? Please describe the symptoms & be specific:

How did you hear about us: _____



Prostate & Testicular History

Age of first intercourse experience: _____

Are you currently sexually active: YES NO

Have you had any sexually transmitted diseases (STDs): YES NO

Please list: _____

Have you had a sperm count: YES NO
What were the results of the sperm count: _____

Have you had the mumps: YES NO
When did you have the mumps: _____

Have you ever had testicular cancer: YES NO
What type of treatment did you receive: _____

Do you have prostate problems: YES NO

Do you have or have you had prostatitis: YES NO

Is your prostate enlarged: YES NO

Have you ever had prostate cancer: YES NO
What type of treatment did you receive: _____

Have you had blood in your urine: YES NO
If yes, when did this occur: _____
Please describe treatment used: _____

Do you have bladder or kidney issues: YES NO
If yes, please describe current treatment, if any: _____

Do you have erectile dysfunction: YES NO
If yes, please describe: _____



Are you suffering from the following (please check all that apply)

- Fatigue: YES NO
- Decrease of memory: YES NO
- Decrease in energy level: YES NO
- Decrease in sexual desire: YES NO

Are you suffering from the following (please check all that apply)

- Anxiety: YES NO
- Irritability: YES NO
- Mood swings: YES NO
- Migraines: YES NO
- Memory loss: YES NO
- Foggy thinking: YES NO
- Muscle loss: YES NO
- Poor response to exercise: YES NO
- Poor recovery from exercise: YES NO

Please describe the way in which these issues have been dealt with:

- Do you initiate intercourse: YES NO
- Is intercourse satisfying: YES NO
- Do you achieve orgasm: YES NO
- Do you suffer from premature ejaculation: YES NO
- How often do you have intercourse: _____
- Is your sex drive similar as it was five years ago: YES NO

Please describe:

List any other sexual dysfunctions:



Have you experienced weight gain in the last 1-2 years: YES NO
If yes, please describe: _____

Have you lost more than 10 pounds in less than a month: YES NO
If yes, why: _____

Have you ever been tested for HIV/AIDS: YES NO
Are you HIV positive: YES NO
If yes, when did this occur: _____
Please describe: _____

Have you fathered any children: YES NO
If yes, how many: _____

Do you plan to have children in the near future? YES NO

Have you ever had your testosterone level taken in the past: YES NO
If yes, why: _____

Please check the box that best describes your sexual orientation:

Heterosexual Homosexual Bisexual

MEDICAL HISTORY

Do you have **diabetes**: YES NO

Do you have or have you ever had **hypertension**: YES NO

Do you have **heart disease**: YES NO

Have you ever had a heart attack or stroke: YES NO

Have you ever had lung cancer: YES NO

If yes, please describe treatment used: _____

Have you ever had colon polyps: YES NO

If yes, please describe treatment used: _____

Have you ever had stomach/intestinal cancer: YES NO

If yes, what type: _____

Please describe treatment used: _____

Have you ever had leukemia or lymphoma: YES NO

If yes, what type: _____

Please describe treatment used: _____

Do you have a **heart murmur**: YES NO

Do you have or have you ever had **kidney disease**: YES NO

Have you ever been treated for a **psychiatric disorder**: YES NO

If yes, please name the disorder: _____

Have you ever had **rheumatic fever**: YES NO

Do you have **mitral valve prolapse**: YES NO

Have you ever had a **urinary tract infection**: YES NO

Have you ever had **hepatitis**: YES NO

If yes, please check which type:

Hepatitis A Hepatitis B Hepatitis C Other

Have you ever had **liver disease**: YES NO

Have you ever had **varicose veins**: YES NO



Have you ever had **phlebitis**: YES NO

Do you have any **thyroid problems**: YES NO

If yes, please check the problem:

Low Function Overactive Goiter Hashimoto

Have you ever had a **blood transfusion**: YES NO

Do you have a **lung disease**: YES NO

Do you have **asthma, emphysema or chronic bronchitis**: YES NO

Do you have **lupus, scleroderma, collagen disease**: YES NO

Do you have **arthritis**: YES NO

If yes, what type: _____

Have you had any **major accidents**: YES NO

Do you have any **drug allergies**: YES NO

If yes, please list the drugs you are allergic to: _____

Have you ever had any problems with your blood YES NO

If yes, please list the blood problems (such as anemia and excess blood cells): _____

Have you ever had multiple myeloma: YES NO

Please describe treatment used: _____

Please list all operations/hospitalizations (including year and reason):

Have you ever had any anesthesia complications: YES NO

If yes, please explain: _____

Do you have an Internist or Family Physician: YES NO

Please list the name of the physician and a number where they may be reached:

Physician Name: _____ Physician Phone Number: _____



Are you currently taking any medications: YES NO

Please list the medications your are currently taking and the dosage amount:

Have you ever had your cholesterol checked: YES NO

If yes, what was the date it was last checked:

How was your cholesterol: Low Normal High

SOCIAL HISTORY

Do you smoke cigarettes: YES NO

If yes, please to try list the number you smoke per day on average:

Please list the number of years you have been smoking:

Do you use recreational drugs: YES NO

Do you drink alcohol: YES NO

If yes, what type of alcohol do you drink:

How many drinks **per week** , on average, do you drink:

Are you using any form of Testosterone or Hormone Therapy: YES NO

If yes, please check which type:

Gel Cream Shots Pellets Other