



**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:*

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How did you hear about us?:

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**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:                     | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Irritability:                | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Mood swings:                 | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Migraines:                   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Memory loss:                 | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Foggy thinking:              | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Muscle loss:                 | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Poor response to exercise:   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Poor recovery from exercise: | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

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

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- |   |                              |                             |
|---|------------------------------|-----------------------------|
| Do you initiate intercourse:                        | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Is intercourse satisfying:                          | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you achieve orgasm:                              | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you suffer from premature ejaculation:           | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| How often do you have intercourse:                  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Is your sex drive similar as it was five years ago: | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Please describe:

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List any other sexual dysfunctions:

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- |   |                              |                             |
|---|------------------------------|-----------------------------|
| Have you experienced weight gain in the last 1-2 years: | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|---|------------------------------|-----------------------------|

If yes, please describe: \_\_\_\_\_

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- |   |                              |                             |
|---|------------------------------|-----------------------------|
| Have you lost more than 10 pounds in less than a month: | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|---|------------------------------|-----------------------------|

If yes, why: \_\_\_\_\_

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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: \_\_\_\_\_

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

List all current medications and dosage amount: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 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 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