



Bio Identical Hormone Replacement
Achieving Hormone BalanceNaturally

MALE PATIENT INFORMATION

Name: _____ Today's Date: _____
LAST FIRST MIDDLE

Date of Birth: _____

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 : _____

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: _____



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

How did you hear about us?

Please remember that insurance does not cover the consult visit or procedure . We expect that our charges for the office visits are paid at the conclusion of each visit.

I authorize the release of information from my primary care physician or specialist if deemed necessary for treatment.

Signature: _____ Date: _____



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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



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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: | YES | NO |
| 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: _____ | | |



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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 circle 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: _____



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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	



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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