



Male Patient Questionnaire & History

Name: _____ Today's Date: _____
(Last) (First) (Middle)

Date of Birth: _____ Age: _____ Weight: _____ Occupation: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

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

In Case of Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Primary Care Physician's Name: _____ Phone: _____

Address: _____
Address City State Zip

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.

Spouse's Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Social:

- () I am sexually active.
- () I want to be sexually active.
- () I have completed my family.
- () I have used steroids in the past for athletic purposes.

Habits:

- () I smoke cigarettes or cigars _____ a day.
- () I drink alcoholic beverages _____ per week.
- () I drink more than 10 alcoholic beverages a week.
- () I use caffeine _____ a day.



Medical History

Any known drug allergies: _____

Have you ever had any issues with anesthesia? () Yes () No

If yes please explain: _____

Medications Currently Taking: _____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Nutritional/Vitamin Supplements: _____

Surgeries, list all and when: _____

Other Pertinent Information: _____

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"/> Hemochromatosis. | <input type="checkbox"/> Diabetes. |
| <input type="checkbox"/> Depression/anxiety. | <input type="checkbox"/> Thyroid disease. |
| <input type="checkbox"/> Psychiatric Disorder. | <input type="checkbox"/> Arthritis. |
| <input type="checkbox"/> Cancer (type): _____ | |
| Year: _____ | |

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. 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.

Print Name

Signature

Today's Date