**PERSONAL INFORMATION**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_

Marital status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of spouse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY NOTIFICATION**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL AGREEMENT**

I understand that all services are rendered on a cash, check, or credit card basis. Unless other arrangements

have been made and approved, I agree to pay for each session at the time of the session. I also agree to the

$20 returned check charge in the event that your check is returned.

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT HEALTH CONDITION**

Primary Purpose of this consultation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**HABITS (Please circle responses):**

Alcohol: None Less than 2 drinks per day Greater than 2 drinks per day or stopped recently \_\_\_\_\_\_\_\_\_\_\_\_

Caffeine: None Less than 2 drinks per day Greater than 2 drinks per day or stopped recently \_\_\_\_\_\_\_\_\_\_\_\_

Soda: None Less than 2 drinks per day Greater than 2 drinks per day or stopped recently \_\_\_\_\_\_\_\_\_\_\_\_

Sweets / Refined Carbs: None Less than 2 per day Greater than 2 per day

Sleep: Difficulty falling asleep\_\_\_ Continuity disturbances \_\_\_ Early morning awakenings \_\_Daytime drowsiness\_\_\_

Smoking: Yes No Packs daily \_\_\_\_\_ How long \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Interested in stopping? \_\_\_\_\_\_\_\_

Stress Levels (1 = Low, 10 = Extreme): 1 2 3 4 5 6 7 8 9 10

How Do You Rate Your Stress Handling (1 = Low, 10 = Extreme): 1 2 3 4 5 6 7 8 9 10

Exercise routine: Never Rarely Sometimes Regularly Competitively

**MEDICATIONS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**DRUG ALLERGIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SUPPLEMENTS TAKEN:** *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
| Ringing in Ear | Gall Bladder Trouble | Tremor/Hands Shaking | Earing Infections – Frequent |
| Jaundice/Hepatitis | Muscle Weakness | Dizziness/Fainting | Change in Bowel Habits |
| Numbness/Tingling Sensations | Failing Vision | Diarrhea | Constapation |
| Headaches – Frequent | Eye Infections | Diverticulosis | Crohns/Colitis |
| Arthritis / Rheumatism | Nose Bleeds | Bloody or Tarry Stools | Osteoporosis |
| Sinus Trouble | Hemorrhoids | Back Pain - Recurring | Sore Throats - Frequent |
| Hernia | Bone Fracture / Joint Injury | Hayfever/Allergies | Urine Infections - Frequent |
| Gout | Pneumonia | Blood in Urine | Foot Pain |
| Cold Numb Feet | Bronchitis / Chronic Cough | Urination - Frequent | Rashes |
| Hives | Asthma / Wheezing | Psoriasis | Eczema |
| Chest Pain | Nervousness | Depression | High Blood Pressure |
| Kidney Stones | Memory Loss | Heart Murmur | Venereal Disease |
| Moodiness - Excessive | Swollen Ankles | Urethral Discharge | Phobias |
| Leg Pain when Walking | Chronic Fatigue | Mentel Illness | Varicose Veins / Phlebitis |
| Weight Loss - Recent | Lactose Intolerance | Loss of Appetite | Anemia |
| Bruise Easily | Difficulty Swallowing | Cancer | Sexual / Menstrual Dysfunction |
| Indigestion or Heartburn | Diabetes | Frequent Infections | Persistent Nausea / Vomiting |
| Thyroid Disease | Diphtheria | Peptic Ulcers | Convulsions / Seizures |
| Tetanus | Abdominal Pain - Chronic | Stroke | Chicken Pox |
| Polio | Mumps | Measles | Rubella |
| Decrease Muscle Mass | Reduce Energy | Erectile Dysfunction | Hoarseness |
| Bulging Eyes | Slowed Reflexes | Cold Body Temperature |  |

**FAMILY HISTORY**

**PLEASE GIVE THE FOLLOWING INFORMATION ABOUT YOUR IMMEDIATE FAMILY**

|  |  |  |  |
| --- | --- | --- | --- |
| **Relationship** | **Age (if Living)** | **Age at Death** | **State of health or cause of death** |
|  |  |  |  |
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**HOSPITALIZATIONS**

|  |  |
| --- | --- |
| **Date** | **Reason** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**HAVE ANY BLOOD RELATIVES HAD THE FOLLOWING ILLNESSES? IF SO, PLEASE INDICATE RELATIONSHIP**

|  |  |
| --- | --- |
| **Illness** | **Relationship** |
| Prostate Cancer |  |
| Diabetes |  |
| Cancer |  |
| Blood Disease |  |
| Glaucoma |  |
| Epilepsy |  |
| Rheumatoid Arthritis |  |
| Tuberculosis |  |
| Gout |  |
| High Blood Pressure |  |
| Heart Disease |  |
| Back Problems |  |

**INSTRUCTIONS: Check either “Ongoing” or “Just w/Period” for each problem that applies to you. Check both if the problem is ongoing and worse with your period. Then rate the severity. Add any additional information in the appropriate column**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Signs & Symptoms** | **Mild** | **Moderate** | **Severe** | **Additional Information** |
| Mood swings |  |  |  |  |
| Anxiety/Nervousness |  |  |  |  |
| Overly Reactive |  |  |  |  |
| Irritability |  |  |  |  |
| Depression |  |  |  |  |
| Lowered Self Esteem |  |  |  |  |
| Caretake others before yourself |  |  |  |  |
| Sadness/Crying |  |  |  |  |
| Foggy Thinking |  |  |  |  |
| Memory Difficulties |  |  |  |  |
| Fatigue |  |  |  |  |
| Constant Hunger |  |  |  |  |
| Sweet Cravings |  |  |  |  |
| Caffeine / Stimulant Cravings |  |  |  |  |
| Salt Cravings |  |  |  |  |
| Headaches/Migraines |  |  |  |  |
| Body/Joint/Back Aches |  |  |  |  |
| Weight Gain |  |  |  |  |
| Weight Loss |  |  |  |  |
| Water Retention |  |  |  |  |
| Bloating |  |  |  |  |
| Irritable Bowel |  |  |  |  |
| Constipation |  |  |  |  |
| Light Colored Stool |  |  |  |  |
| Loose Stool/Diarrhea |  |  |  |  |
| Nausea/Vomiting |  |  |  |  |
| Acne |  |  |  |  |
| Excessive Facial Hair |  |  |  |  |
| Body/Head Hair Loss |  |  |  |  |
| Dry skin/Brown Spots |  |  |  |  |
| Lowered Libido |  |  |  |  |
| Heightened Libido |  |  |  |  |
| Excessive Sweating |  |  |  |  |
| Night Sweats |  |  |  |  |
| Breast Tenderness |  |  |  |  |
| Urinary Frequency |  |  |  |  |
| Incontinence |  |  |  |  |

**Have you had any of the following tests?** *(please circle the appropriate answer)*

PSA Yes (Date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No Abnormal? Yes No

DEXA Scan (Bone Density) Yes (Date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No Abnormal? Yes No

Colonoscopy Yes (Date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No Abnormal? Yes No

**SLEEP HABITS**

1. How do you sleep? Well Trouble falling asleep Trouble staying asleep Insomnia

How long has this been happening? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How many hours do you sleep a night on average? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Do night sweats wake you up? Yes No How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Do you wake up tired? Yes No How long has this been happening? \_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Is your room completely dark when you sleep at night (no night light, street lamp, TV)? Yes No
5. Do you get at least 30 minutes of outside daylight several days each week? Yes No

**TESTOSTERONE TEST**

1. Do you have a decrease in libido (sex drive)? Yes No
2. Do you have a lack of energy? Yes No
3. Do you have a decrease in strength and/or endurance? Yes No
4. Have you lost height? Yes No
5. Have yo unnoticed a decreased “enjoyment of life”? Yes No
6. Are you sad and/or grumpy? Yes No
7. Are your erections less strong? Yes No
8. Have you noticed a recent deterioration in your ability in sports? Yes No
9. Are you falling asleep after dinner? Yes No
10. Has there been a recent deterioration in your work performance? Yes No