Skip the Line - Medical Clinic
3295 Crawfordville Hwy, Suite 11
Crawfordville, FL 32327
Phone: (448)220-6053
Email: skipthelineclinic@gmail.com

Intake History

* indicates a required field

Please answer these questions truthfully and to the best of your knowledge. This will allow us to design a treatment plan specifically designed for you. Your honest answers are greatly appreciated. If it does not apply, write N/A.

Personal Health History

* How did you hear about us?

* What are your goals for treatment? Do you have any specific concerns you would like addressed?

* Please list any medical conditions you have been diagnosed with such as high blood pressure.

Surgeries:

Hospitalizations:

Have you ever been on testosterone replacement? Please describe your history of prescribed or illicit steroid use:

List any medications or supplements you are taking:

* Please list any drug allergies you have:

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Health Habits

* Exercise:
- [ ] Sedentary
- [ ] Mild exercise
- [ ] Moderate exercise
- [ ] Regular vigorous exercise

* Are you dieting?

* Please describe your alcohol intake:

* Do you use tobacco? How much?

* Do you use any recreational or street drugs? If so, what?

* Are you sexually active?
- ( ) Yes
- ( ) No

*Any discomfort with intercourse?
- [ ] Yes
- [ ] No

*Have you been diagnosed with HIV?
- ( ) Yes
- ( ) No

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Family Health History

* Please describe your family health history. Please include conditions such as prostate cancer, heart attacks, stroke, diabetes, high blood pressure etc. Please also include their age or if they are deceased.

- [ ] Father
- [ ] Mother
- [ ] Paternal Grandmother
- [ ] Paternal Grandfather
- [ ] Maternal Grandmother
- [ ] Maternal Grandfather
- [ ] Siblings
- [ ] Children
- [ ] Unknown

Mental Health

* Do you have anxiety problems?

- ( ) Yes
- ( ) No

* Do you feel depressed?

- ( ) Yes
- ( ) No

* Do you have problems with eating or your appetite?

- ( ) Yes
- ( ) No

* Do you feel unmotivated in life?

- ( ) Yes
- ( ) No

* Do you have trouble sleeping?

- ( ) Yes
- ( ) No

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Genitourinary Health

* Do you have to get up to urinate at night?
- Yes
- No

* Do you have discomfort with urination?
- Yes
- No

* Has the force of your urination decreased?
- Yes
- No

* Have you had any kidney, bladder, or prostate infections within the last 12 months?
- Yes
- No

* Do you have any problems emptying your bladder completely?
- Yes
- No

* Do you have problems achieving or maintaining an erection?
- Yes
- No

* Are your erections softer than they used to be?
- Yes
- No

* Do you have ejaculation issues?
- Yes
- No

* Any testicle pain or swelling?
- Yes
- No

* Date of last prostate and rectal exam _____

Please explain any yes answers from the previous questions or tell us anything else you would like us to know:

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Other recent problems:

* Please check if you have any additional issues and briefly explain:

- ☐ Skin
- ☐ Head/Neck
- ☐ Ears/Throat/Nose
- ☐ Lungs
- ☐ Chest/Heart
- ☐ Joint/Muscle/Back
- ☐ Gastrointestinal
- ☐ Bladder
- ☐ Mental health
- ☐ Athletic performance
- ☐ Recent changes in weight
- ☐ Recent changes in energy levels
- ☐ Recent changes in ability to sleep
- ☐ Not applicable

* Please rate each problem from a scale to 1-10, with 1 being never and 10 being often:

- ☐ _____ Low mood/Depression
- ☐ _____ Irritability
- ☐ _____ Anxiety
- ☐ _____ Anger
- ☐ _____ Discouragement
- ☐ _____ Decreased interest in activities or relationships
- ☐ _____ Decreased productivity at work
- ☐ _____ Decreased motivation/ drive/initiative
- ☐ _____ Concentration problems
- ☐ _____ Memory problems
- ☐ _____ Foggy thinking
- ☐ _____ Lower libido/sex drive
- ☐ _____ Erection problems
- ☐ _____ Increased fatigue
- ☐ _____ Decrease in muscle mass
- ☐ _____ Decrease in athletic performance
- ☐ _____ Muscle soreness/fatigue
- ☐ _____ Decrease in strength
- ☐ _____ Joint problems
- ☐ _____ Elevated blood pressure
- ☐ _____ Blood sugar problems
- ☐ _____ Sweet/carb cravings
- ☐ _____ Caffeine Cravings
- ☐ _____ Increased fat on hips/abdomen/ thighs/chest
- ☐ _____ Weight loss
- ☐ _____ Weight gain
- ☐ _____ Hair loss
- ☐ _____ Anything else you would to mention