



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

# MALE PATIENT QUESTIONNAIRE & HISTORY

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

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Occupation: \_\_\_\_\_

Home Address: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work: \_\_\_\_\_

Preferred contact number: \_\_\_\_\_

May we send messages via text regarding appts to your cell?  Yes  No

Email Address: \_\_\_\_\_ May we contact you via email?  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 have 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.

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work: \_\_\_\_\_

### Social:

I smoke cigarettes or cigars \_\_\_ per day.  I use caffeine \_\_\_ per day.  I use e-cigarettes \_\_\_ per day.

I have completed my family.  My partner and I would like to have more children in the near future.

I have no biological children. If this is true, have you tried to have children?  Yes  No

If you have not had children, have you had prior semen analysis?  Yes  No



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# MALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

### Family History:

- Heart disease
- Diabetes
- Osteoporosis
- Alzheimer's or dementia
- Prostate cancer

### Medication & Other Pertinent Information

Any known drug allergies: \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

Have you ever had any issues with local anesthesia?  Yes  No Do you have a latex allergy?  Yes  No

Medications Currently Taking: \_\_\_\_\_

Current Testosterone Replacement?  Yes  No If yes, are you on estrogen blocker?  Yes  No

Past Testosterone Replacement Therapy: \_\_\_\_\_

### Pertinent Medical/Surgical History:

- |   |   |
|---|---|
| <input type="checkbox"/> Cancer (type):<br>Year: _____                        | <input type="checkbox"/> Testicular or prostate cancer                |
| <input type="checkbox"/> Elevated PSA   | <input type="checkbox"/> Prostate enlargement or BPH                  |
| <input type="checkbox"/> Trouble passing urine                                | <input type="checkbox"/> Kidney disease or decreased kidney function  |
| <input type="checkbox"/> Taking medicine for prostate or male-pattern balding | <input type="checkbox"/> Frequent blood donations                     |
| <input type="checkbox"/> History of anemia                                    | <input type="checkbox"/> Non-cancerous testicular or prostate surgery |
| <input type="checkbox"/> Vasectomy  | <input type="checkbox"/> Severe snoring                               |
| <input type="checkbox"/> Erectile dysfunction                                 | <input type="checkbox"/> Taking medicine for high cholesterol         |

### Other Medical Conditions:

- |   |  |
|---|--|
| <input type="checkbox"/> High blood pressure or hypertension  | <input type="checkbox"/> High cholesterol                  |
| <input type="checkbox"/> Heart disease  | <input type="checkbox"/> Stroke and/or heart attack        |
| <input type="checkbox"/> Atrial fibrillation or other arrhythmia                                    | <input type="checkbox"/> HIV or any type of hepatitis      |
| <input type="checkbox"/> Blood clot and/or a pulmonary emboli                                       | <input type="checkbox"/> Hemochromatosis                   |
| <input type="checkbox"/> Depression/anxiety   | <input type="checkbox"/> Psychiatric disorder              |
| <input type="checkbox"/> Chronic liver disease (hepatitis, fatty liver, cirrhosis)                  | <input type="checkbox"/> Thyroid disease                   |
| <input type="checkbox"/> Taking Proscar (finasteride), Flomax (Tamsulosin) or Avodart (dutasteride) | <input type="checkbox"/> Diabetes                          |
| <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Thyroid disease                   |
| <input type="checkbox"/> Hair thinning  | <input type="checkbox"/> Lupus or other autoimmune disease |
| <input type="checkbox"/> Sleep apnea  | <input type="checkbox"/> Other _____                       |

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## MALE HEALTH ASSESSMENT

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "none".

Symptoms	Never (0)	Mild (1)	Moderate (2)	Severe (3)	Very Severe (4)
Sweating (night sweats or excessive sweating)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep problems (difficulty falling asleep, sleeping through the night or waking up too early)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased need for sleep or falls asleep easily after a meal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressive mood (feeling down, sad, lack of drive)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability (mood swings, feeling aggressive, angers easily)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety (inner restlessness, feeling panicked, feeling nervous, inner tension)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual problems (change in sexual desire or in sexual performance)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder problems (difficulty in urinating, increased need to urinate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Erectile changes (weaker erections, loss of morning erections)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulties with memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problems with thinking, concentrating or reasoning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty learning new things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble thinking of the right word to describe persons, places or things when speaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increase in frequency or intensity of headaches/migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rapid hair loss or thinning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel cold all the time or have cold hands or feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain, increased belly fat, or difficulty losing weight despite diet and exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infrequent or absent ejaculations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total score	_____				