



## Male Patient History

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Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ ft \_\_\_\_\_ in

Usual Weight: \_\_\_\_\_ Recent weight loss or gain? \_\_\_\_\_

### What is your main reason for this appointment?

**Medical History:** Your Private Physician: \_\_\_\_\_ Urologist: \_\_\_\_\_

Approx date of last exam by your private physician: \_\_\_\_\_ Last prostate exam: \_\_\_\_\_

Prior **Hormone Therapy** (Testosterone, HCG, HGH) \_\_\_\_\_

Have you ever used anabolic ("weightlifter") steroids? \_\_\_\_\_

Known **Allergies** to medicines: \_\_\_\_\_

Current **prescription medications and supplements** taken: \_\_\_\_\_

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### Medical Illnesses/Health Problems

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> High Cholesterol                                 | <input type="checkbox"/> Elevated PSA               | <input type="checkbox"/> High blood pressure           |
| <input type="checkbox"/> Heart disease                                    | <input type="checkbox"/> Enlarged prostate          | <input type="checkbox"/> Testicular or prostate cancer |
| <input type="checkbox"/> Stroke and/or heart attack                       | <input type="checkbox"/> Problems urinating         | <input type="checkbox"/> Migraine headaches            |
| <input type="checkbox"/> Blood clot in leg or lung                        | <input type="checkbox"/> Cancer:                    |  |
| <input type="checkbox"/> Excessive bleeding when cut                      | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Thyroid disease               |
| <input type="checkbox"/> Depression/anxiety                               | <input type="checkbox"/> Other psychiatric disorder | <input type="checkbox"/> Low testosterone              |
| <input type="checkbox"/> Hemochromatosis ( iron storage disease)          |   | <input type="checkbox"/> History of concussion         |
| <input type="checkbox"/> Chronic liver disease (hepatitis or fatty liver) |   | <input type="checkbox"/> Other:                        |

**Past Surgeries (include dates):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Family History** of prostate cancer? YES NO If yes, what relationship to you? \_\_\_\_\_

**Other Family History** (diabetes, heart attack, stroke, etc): \_\_\_\_\_

**Tobacco Use:** \_\_\_\_\_ for \_\_\_\_\_ years **Alcohol Use:** Never Occasional Regular

Do you **exercise** regularly? If so, what type and how often \_\_\_\_\_

\_\_\_\_\_

How many hours do you **sleep** in a typical night? \_\_\_\_\_

Approx. # of servings **vegetables and fruits** eaten daily: \_\_\_\_\_

Your typical **breakfast** foods: \_\_\_\_\_

Typical **lunch:** \_\_\_\_\_

Typical **evening meal:** \_\_\_\_\_

\_\_\_\_\_

**# of Soft drinks/ sweet teas** consumed daily: \_\_\_\_\_ Have you ever tried a wheat-free diet? \_\_\_\_\_

How did you find out about this office? \_\_\_\_\_

**Other pertinent health information:**

Print Name

Signature

Date