



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: _____

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