MALE PATIENT QUESTIONNAIRE & HISTORY

Name: _____________________________________ Date:__________________ Date of Birth: ___________________

Age: _____ Height: ______ Weight: ______ Occupation: ____

Home address: ____

City: ____________________________ State: _______________________________ Zip: ________________________

Home phone: ________________________ Cell: ________________________ Work: ___________________________

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

Email address: ____

In case of emergency contact: _______________________________ Relationship: _____________________________

Home phone: ________________________ Cell: ________________________ Work: __________________________

Primary care physician's name: _______________________________________ Phone: _________________________

Address: ____

Marital status (check one): ▢ Married ▢ Divorced ▢ Widow ▢ Single ▢ Living with partner

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: __________________________ Phone: __________________

SOCIAL HISTORY

▢ I am sexually active OR ▢ I want to be sexually active

▢ I have completed my family OR ▢ I have NOT completed my family

▢ My sex life has suffered OR ▢ I have not been able to have an orgasm, or it is difficult

▢ I do not want to be sexually active

HABITS

▢ I smoke cigarettes/cigars _____ per day ▢ I use e-cigarettes _____ a day. ▢ I use caffeine _____ per day

▢ I drink alcoholic beverages _____ per week ▢ I drink more than 10 alcoholic beverages a week

Activity Level (please circle): low moderate average high

DRUG ALLERGIES

Drug allergies ▢ Yes ▢ No If yes, explain ____

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

CURRENT MEDICATIONS

____

____

____

Are you currently taking thyroid medication? ▢ Yes ▢ No If yes, what type? ______________________________

Are you currently taking statins for cholesterol? ▢ Yes ▢ No

Are you currently on a 5a reductase? ▢ Yes ▢ No If yes, what type? ____________________________________

Current hormone replacement therapy? ▢ Yes ▢ No If yes, what? ______________________________________

Past hormone replacement therapy? ____

Last physical? ___________________ Last prostate check? __________________

FAMILY HISTORY

▢ Heart disease ▢ Diabetes ▢ Osteoporosis ▢ Alzheimer's/dementia ▢ Breast cancer

▢ Other ____

PERTINENT MEDICAL/SURGICAL HISTORY

▢ Cancer (type)_____ ▢ Seizures ▢ Hashimoto's thyroiditis

▢ Elevated PSA ▢ History of anemia ▢ Taking medications for male pattern balding

▢ Trouble passing urine ▢ Erectile dysfunction ▢ Taking medications for prostate

▢ Vasectomy ▢ Kidney disease ▢ Previous urology visit

▢Frequent blood donations ▢ Severe snoring ▢ Testicular or prostate cancer

▢ Non-cancerous testicular or prostate surgery ▢ Prostate enlargement or BPH

BIRTH CONTROL

▢ Not applicable ▢ None - planning pregnancy in the next year ▢ Condoms

▢ Vasectomy ▢ Depend on partner's contraception

▢ Infertility ▢ Other ________________

MEDICAL HISTORY

▢ High blood pressure/hypertension ▢ Stroke and/or heart attack

▢ Heart disease ▢ HIV or hepatitis

▢ Atrial fibrillation or other arrhythmia ▢ Hemochromatosis

▢ Blood clot and/or pulmonary embolism ▢ Psychiatric disorder

▢ Depression/anxiety ▢ Thyroid disease

▢ Chronic liver disease (fatty liver, cirrhosis) ▢ Diabetes

▢ Arthritis ▢ Lupus or other autoimmune disease

▢ Sleep apnea ▢ High cholesterol

▢ Other ________________________________ ▢ Hair thinning