Male: New Patient

Name: ____________________ Date: __________

Birth Date: _____________

PATIENT INFORMATION

Age: ____________

Weight: __________

Activity Level:

- ☐ Low
- ☐ Moderate
- ☐ Medium High
- ☐ High

MEDICAL HISTORY

- ☐ Propecia
- ☐ Proscar
- ☐ Finasteride
- ☐ Urological Work-Up Performed & OK
- ☐ Prostate Cancer
  How was it treated:

  ____

* Cancer Free
  - o Less than 2 years
  - o More than 2 years

- ☐ Low Thyroiditis
- ☐ Currently on Thyroid Medication
  - o Desiccated Thyroid
  - o Synthroid Dosage ______

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Male Patient Questionnaire & History

Name: ____ Today's Date: __________
(Last) (First) (Middle)

Date of Birth:__________ Age:_____ Weight:______ Occupation:____________________

Home Address: ____

City: ______________________________________ State: ________ Zip: __________

Home Phone: ______________ Cell Phone: ______________ Work: ______________

E-Mail Address: ____________________________ May we contact you via E-Mail? ( ) **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 mean's you've 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.

Spouse's Name: ______________________________ Relationship: ______________

Home Phone: ______________ Cell Phone: ______________ Work: ______________

Social:

( ) I am sexually active.
( ) I want to be sexually active.
( ) I have completed my family.
( ) I have used steroids in the past for athletic purposes.

Habits:

( ) I smoke cigarettes or cigars ______________ a day.
( ) I drink alcoholic beverages ______________ per week.
( ) I drink more than 10 alcoholic beverages a week.
( ) I use caffeine ______________ a day.

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BHRT Checklist For Men

Name: ______________________________ Date: ______________

E-Mail: ______________________

Symptom *(please check mark)*

Symptom	Never	Mild	Moderate	Severe
Decline in general well being				
Fatigue				
Joint pain/muscle ache				
Excessive sweating				
Sleep problems				
Increased need for sleep				
Irritability				
Nervousness				
Anxiety				
Depressed mood				
Exhaustion/lacking vitality				
Declining Mental Ability/Focus/Concentration				
Feeling you have passed your peak				
Feeling burned out/hit rock bottom				
Decreased muscle strength				
Weight Gain/Belly Fat/Inability to Lose Weight				
Breast Development				
Shrinking Testicles				
Rapid Hair Loss				
Decrease in beard growth				
New Migraine Headaches				
Decreased desire/libido				
Decreased morning erections				
Decreased ability to perform sexually				
Infrequent or Absent Ejaculations				
No Results from E.D. Medications				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		

Medical Insurance Form

Last Name:________________ Initial:______ First Name:________________

Date of Birth:____________ Gender:______ SSN:________________

Primary Address:____________________ ZIP:________ City:______________

State:__________ Primary Phone Number:______________

Primary Email:________________________

Responsible Party

Last Name:________________ Initial:______ First Name:________________

Relationship:______________

Primary Address:____________________ ZIP:________ City:______________

State:__________ Primary Phone Number:______________

Insurance Information:

Insurance Name:___________________ Subscriber number:________________

Group:________________ Address:____________________ ZIP:________

City:____________ State:__________ Phone Number:______________

Patient relationship:______________ Subscriber Name:__________________

Primary Address:____________________ ZIP:________ City:______________

State:__________ Primary Phone Number:______________