

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:

- | | | | |
|--|----|--|---|
| <input type="checkbox"/> I am sexually active. | OR | <input type="checkbox"/> I want to be sexually active. | <input type="checkbox"/> I do not want to be sexually active. |
| <input type="checkbox"/> I have completed my family. | OR | <input type="checkbox"/> I have NOT completed my family. | |
| <input type="checkbox"/> My sex life has suffered. | OR | <input type="checkbox"/> I have not been able to have an orgasm or it is very difficult. | |

Habits:

- | | | |
|--|---|--|
| <input type="checkbox"/> I smoke cigarettes or cigars _____ per day. | <input type="checkbox"/> I use e-cigarettes _____ a day. | <input type="checkbox"/> I use caffeine _____ a day. |
| <input type="checkbox"/> I drink alcoholic beverages _____ per week. | <input type="checkbox"/> I drink more than 10 alcoholic beverages a week. | |

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MALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

Drug allergies

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 hormone replacement? Yes No If yes, what? _____

Past hormone replacement therapy: _____

Family history:

Heart disease Diabetes Osteoporosis Alzheimer's/dementia Breast cancer Other _____

Pertinent medical/surgical history:

- | | |
|--|--|
| <input type="checkbox"/> Cancer (type):
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 |

Birth Control Method:

- Not applicable
 None - planning pregnancy
in the next year
 Depend on partner's
contraception
 Vasectomy
 Condoms
 Other: _____

Activity Level:

- Low - sedentary
 Moderate - walk/jog/workout infrequently
 Average - walk/jog/workout 1 to 3 times per week
 High - walk/jog/workout regularly 4+ times per week

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MALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

Medical history:

- | | |
|--|--|
| <input type="checkbox"/> High blood pressure or hypertension | <input type="checkbox"/> Stroke and/or heart attack |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> HIV or any type of hepatitis |
| <input type="checkbox"/> Atrial fibrillation or other arrhythmia | <input type="checkbox"/> Hemochromatosis |
| <input type="checkbox"/> Blood clot and/or a pulmonary embolism | <input type="checkbox"/> Psychiatric disorder |
| <input type="checkbox"/> Depression/anxiety | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Chronic liver disease (hepatitis, fatty liver, cirrhosis) | <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 _____ |
| <input type="checkbox"/> High cholesterol | |