



**TIER 1**  
**HEALTH AND WELLNESS**  
**Tier1HW.com**

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**HEALTH AND WELLNESS MALE CONSULTATION MEDICAL HISTORY**

**NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**PHONE #:** \_\_\_\_\_ **E-mail:** \_\_\_\_\_

**DOB:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_ **Marital Status:** \_\_\_\_\_

My Primary Health Concerns

Allergies: \_\_\_\_\_

Primary care doctor: \_\_\_\_\_ Phone #: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone #: \_\_\_\_\_

Approximate date of: Last complete physical exam: \_\_\_\_\_

Men: Last prostate exam: \_\_\_\_\_ PSA \_\_\_\_\_

Do you have a history of cancer? If so, what type? \_\_\_\_\_ How long ago? \_\_\_\_\_

Have you ever had a blood clot or been diagnosed with a blood clotting disorder? \_\_\_\_\_

Have you **ever been** on testosterone therapy? \_\_\_\_\_ Are you **currently on** testosterone therapy \_\_\_\_\_

Current Medications - Prescription and Non-Prescription (Name/Dose/Reason for Taking)

Do you smoke? \_\_\_\_\_ How much? \_\_\_\_\_ How often? \_\_\_\_\_ When did you quit? \_\_\_\_\_

Do you use alcohol? \_\_\_\_\_ (Type and how much per week) \_\_\_\_\_

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**FAMILY HISTORY**

List any serious problems (ex: cancer, diabetes, arthritis, heart disease) which relative?

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**Males - Complete the Following Section**

Current Symptoms	None	Mild	Mod	Severe
Decline in your general feeling of well being	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Joint pain and muscular aches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Excessive sweating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fatigue	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Irritability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physical exhaustion/lack of vitality	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Decrease in muscular strength	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depressive mood	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Decrease in beard growth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Decrease in sexual desire/libido	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Decrease in number of morning erections	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Decrease in ability/frequency to perform sexually	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling that you have passed your peak	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling burned out, having hit rock bottom	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Weight gain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lack of mental clarity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Communication Preferences**

How do you prefer to be reached?	Best time to reach you?
How did you hear about us?	

Patient signature: \_\_\_\_\_

Date: \_\_\_\_\_

Physician signature: \_\_\_\_\_

Date: \_\_\_\_\_