Tier1HW.com

Keith Nichols, M.D.
Angie Nichols, R.N.
P: 423-417-1700 | 931-520-0200
F: 866-719-8717
2120 Northgate Park Lane Ste 402
Chattanooga, TN 37415

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?

Males - Complete the Following Section

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

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: ____________________