TIER 1
HEALTH AND WELLNESS

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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?

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: ____________________