Rejuvené

MALE PATIENT INFORMATION

Name:_____ **Date of Birth:**_____

Last **First** **Middle** **Date**:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone Numbers: Home:_____ Cell:_____

E-mail Address (for office use only will not be shared):_____

Patient employed by:_____

Occupation:_____

Business Address:_____

Business Phone:_____

In case of emergency, whom should we notify:_____

Emergency Phone Numbers:_____

Marital Status:(Please circle) Married Divorced Single Widow Living with significant other

Soc. Sec, # (required to order pellets):_____

Is it ok to leave a message with lab work results on your voice-mail: (please circle) Yes No

What phone number would you like us to call with lab results and/or appointment reminders?

Phone #: _____

*****Payment is due at time of service.*****

Payment types accepted: Cash, Check, Visa, Mastercard, Discover and American Express

What is your primary health concern or reason for considering bio-identical hormone replacement therapy? _____

_____

SEXUAL HISTORY

1. Are you sexually active? ☐ Yes ☐ No
2. Have you had the mumps? ☐ Yes ☐ No

   Date:_____
3. Have you had testicular cancer? ☐ Yes ☐ No

   Date:_____
4. Do you have prostate problems? ☐ Yes ☐ No

   If yes, please describe:_____
5. Have you had any bladder or kidney problems? ☐ Yes ☐ No

   If yes, when & treatment:_____
6. Do you have erectile dysfunction? ☐ Yes ☐ No

   If yes, please describe:_____
7. Do you have:

   Fatigue? ☐ Yes ☐ No

   Decrease of memory? ☐ Yes ☐ No

   Decrease of energy level? ☐ Yes ☐ No

   Decrease of sexual drive? ☐ Yes ☐ No
8. Do you suffer from:

   Anxiety ☐ Yes ☐ No

   Irritability? ☐ Yes ☐ No

   Mood swings? ☐ Yes ☐ No

   Migraines? ☐ Yes ☐ No
9. How have you dealt with these symptoms?

   _____

   _____

   _____

10. Is your sex drive the same as it was five years ago? □ Yes □ No

    Describe:_____

11. List any other sexual dysfunctions:

    _____

    _____

    _____

12. Have you experienced weight gain in the last one - two years? □ Yes □ No

    If yes, describe?_____

13. Have you lost greater than 10 pounds in less than a month? □ Yes □ No

    If yes, why?_____

14. Have you fathered any children? □ Yes □ No

    If yes, how many? □ Yes □ No

15. Have you had your Testosterone level taken? □ Yes □ No

    Date:_____

16. List current medications:

    _____

    _____

    _____

PAST MEDICAL HISTORY

1. Do you have diabetes? □ Yes □ No
2. Do you have/had hypertension? □ Yes □ No
3. Do you have heart disease? □ Yes □ No
4. Do you have a heart murmur? □ Yes □ No
5. Do you have/had kidney disease? □ Yes □ No
6. Have you ever been treated for psychiatric problems? □ Yes □ No
7. Have you ever had rheumatic fever? □ Yes □ No
8. Do you have mitral valve prolapse? □ Yes □ No

9. Have you ever had a urinary tract infection? □ Yes □ No
10. Have you ever had hepatitis/liver disease? □ Yes □ No
11. Have you ever had varicosities/phlebitis/blood clots? □ Yes □ No
12. Do you have any thyroid problems? □ Yes □ No
13. Have you had any major accidents? □ Yes □ No
14. Have you ever had any blood transfusions? □ Yes □ No
15. Do you have asthma/lung disease? □ Yes □ No
16. Do you have lupus, Scleroderma or similar diseases? □ Yes □ No

    If yes, please describe:_____

17. Do you have arthritis? □ Yes □ No

    If yes, what type:_____

18. Do you have any Drug Allergies? □ Yes □ No

    If yes, please list:_____

19. List any surgeries:

    _____

    _____

    _____

20. List any other operations/hospitalizations (include year & reason):

    _____

    _____

    _____

21. Have you had any anesthesia complications? □ Yes □ No

    If yes, please list:_____

22. Have you ever been anemic? □ Yes □ No
23. Do you have an Internist or Family Doctor? □ Yes □ No

    If yes, please list name and phone number:_____

24. Have you had your cholesterol checked? □ Yes □ No

    If yes, date last checked:_____

    Was it normal? □ Yes □ No

SOCIAL HISTORY

1. Do you smoke cigarettes? □ Yes □ No

   If yes, number per day?_____ Number of years?_____

2. Do you drink alcohol? □ Yes □ No

   If yes, how much per day?_____