

# 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  NoEmail 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):<br>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  |  |

