Male Patient Questionnaire & History

Habits:

( ) I smoke cigarettes or cigars_____ a day.
( ) I drink alcoholic beverages_____ per week.
( ) I drink more than 10 alcoholic beverages a week.
( ) I use caffeine_____ a day.

Medical History (if not listed on H&P)

Current Hormone Replacement
Therapy:_____

Past Hormone Replacement
Therapy:_____

Nutritional/Vitamin
Supplements:_____

History of Steroid use for Athletic purposes: **YES** **NO**

Other Pertinent
Information:_____

Medical Illnesses:

( ) High blood pressure.
( ) High cholesterol.
( ) Heart Disease.
( ) Stroke and/or heart attack.
( ) Blood clot and/or a pulmonary emboli.
( ) Hemochromatosis.
( ) Depression/anxiety.
( ) Psychiatric Disorder.
( ) Cancer (type): _____
Year: _____

( ) Testicular or prostate cancer.
( ) Elevated PSA.
( ) Prostate enlargement.
( ) Trouble passing urine or take Flomax or Avodart.
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis
( ) Diabetes.
( ) Thyroid disease.
( ) Arthritis.

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Male Patient Symptom Checklist

Please check all of your symptoms and indicate severity.

Symptom	Never	Mild	Moderate	Severe
Decline in Overall Well Being				
Fatigue				
Memory Loss				
Joint Pain/Muscle Ache				
Decreased Sex Drive/Libido				
Sleep Problems				
Mood Changes				
Irritability				
Nervousness/Anxiety				
Feeling Burned Out				
Migraines/Headaches				
Difficulty Concentrating				
Decreased Muscle Strength				
Weight Gain/Increased Belly Fat				
Breast Development				
Shrinking Testicles				
Decreased Morning Erections				
Night Sweats				
Dry and/or Wrinkled Skin				
Rapid Hair Loss				
Infrequent or Absent Ejaculation				

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No Result from ED Medications				
Excessive Sweating				

0=Never 1=Mild 2=Moderate 4=Severe

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