MALE PATIENT QUESTIONNAIRE & HISTORY

Name: ______________________________________ Today's Date: _______________
(Last) (First) (Middle)

Date of Birth: ___________ Age: ______ Weight: _________ Occupation: ___________

Home Phone: ____________ Cell Phone: ____________ Work Phone: _____________

Address: ____

City: _____________________________ State: __________ Zip Code: ____________

E-Mail Address: ____

May we contact you via E-Mail? ( ) YES ( ) NO

In Case of Emergency Contact: _______________________ Relationship: __________

Home Phone: ____________ Cell Phone: ____________ Work Phone: _____________

Primary Care Physician's Name: _________________________ Phone: _____________

Address: ____

City: _____________________________ State: __________ Zip Code: ____________

Marital Status {check one}: ( )Married ( )Divorced ( )Widow ( )Living with Partner ( )Single

In the event we cannot contact you by the mean's you've 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.

Spouse's Name: ______________________________ Relationship: ________________

Home Phone: ____________ Cell Phone: ____________ Work Phone: _____________

Insurance: ____

ID#: ______________________________ Group#: _______________________________

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Social:

( ) I am sexually active.

( ) I want to be sexually active.

( ) I have completed my family.

( ) I have used steroids in the past for athletic purposes.

Habits:

( ) I smoke cigarettes or cigars ________ per day.

( ) I drink alcoholic beverages _________ per week.

( ) I drink more than 10 alcoholic beverages a week.

( ) I use caffeine _________ a day.

Randy A. Birken, MD

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MALE PATIENT MEDICAL HISTORY

Any known drug allergies: ____________________

Have you ever had any issues with anesthesia? ( ) Yes ( ) No

If yes please explain: ____________________

Medications Currently Taking: ____________________

Current Hormone Replacement Therapy: ____________________

Past Hormone Replacement Therapy: ____________________

Nutritional/Vitiamin Supplements: ____________________

Last menstrual period (estimate year if unknown): ____________________

Other Pertinent Information: ____________________

Preventative Medical Care:

( ) 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

I understand that if I begin testosterone replacement with any testosterone treatment, including testosterone pellets, that I will produce less testosterone from my testicles and if I stop replacement, I may experience a temporary decrease in my testosterone production. Testosterone Pellets should be completely out of your system in 12 months.

By beginning treatment, I accept all the risks of therapy stated herein and future risks that might be reported. I understand that higher than normal physiologic levels may be reached to create the necessary hormonal balance.

Print Name: ____________________

Patient Signature: ____________________ Date: __________

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BHRT CHECKLIST FOR MEN

Name: ______________________________ Date: ______________

E-Mail: ____

Symptom (please check mark):	Never	Mild	Moderate	Severe
Decline in general well being				
Joint Pain/Muscle Ache				
Excessive Sweating				
Sleep Problems Increased				
Need for Sleep Irritability				
Nervousness				
Anxiety				
Depressed Mood				
Exhaustion/Lacking Vitality				
Declining Mental Ability/Focus/Concentration				
Feeling You have passed your peak				
Feeling Burned Out/Hit Rock Bottom				
Decreased Muscle Strength				
Weight Gain/Belly Fat/Inability to Lose Weight				
Breast Development				
Shrinking Testicles				
Rapid Hair Loss				
Decrease in Beard Growth				
New Migraine Headaches				
Decreased Desire/Libido				
Decreased Morning Erections				
Decreased Ability to Perform Sexually				
Infrequent or Absent Ejaculations				
No Results from E.D.Medications				

Family History	No	Yes
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		

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