



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#: _____

Randy A. Birken, MD



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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.

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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/Vitamin Supplements: _____

Last menstrual period (estimate year if unknown): _____

Other Pertinent Information: _____

Preventative Medical Care:

- | | |
|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Testicular or prostate cancer |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Elevated PSA |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Prostate enlargement |
| <input type="checkbox"/> Stroke and /or heart attack | <input type="checkbox"/> Trouble passing urine or take Flomax or Avodart |
| <input type="checkbox"/> Blood clot and/or a pulmonary emboli | <input type="checkbox"/> Chronic liver disease (hepatitis, fatty liver, cirrhosis) |
| <input type="checkbox"/> Hemochromatosis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Depression/anxiety | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Psychiatric Disorder | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Cancer (type): _____ Year: _____ | |

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: _____

Randy A. Birken, MD



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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