NEW PATIENT (MEN)

Please fill in completely if you are new to our practice, otherwise just update each category on both sides.

Primary Care Physician: _____ Today's Date: _____

Patients Name: _____ Date of Birth: _____

Special concerns you wish to discuss today: _____

Allergies: (include metals, latex, etc.) _____

Medical History: Please list major medical problems, illnesses or injuries _____

_____

Medications: _____

Hospitalizations/Surgeries: _____

_____

Family History	Alive	Deceased	Cause
Mother			
Father			

Social History	Yes	NO		Personal Profile
Tobacco Use			Packs per day:	Martial Status
Alcohol Use			Drinks per week:	Married Since
Drug Use				Previous Martial status
Caffeine Intake				Children
Domestic Violence				Grandchildren
Regular Exercise			How long?	Occupation
Supplements				Residence (own home, condo, apt)
				Hobbies

Personal HX:	Yes	No	Family HX:	Yes	No	Family Member
Depression			Depression			
Hypertension			Hypertension			
Respiratory Disease			Respiratory Disease			
Kidney Disease			Kidney Disease			
Anemia			Anemia			
Thyroid Disease			Thyroid Disease			
Birth Defects			Birth Defects			
Lung Cancer			Lung Cancer			
Skin Cancer			Skin Cancer			
Colerectol Cancer			Colerectol Cancer			
Stomach Cancer			Stomach Cancer			
Liver Cancer			Liver Cancer			
Breast Cancer			Breast Cancer			
Other Cancer			Other Cancer			
Diabetes			Diabetes			
Heart Disease			Heart Disease			
Asthma			Asthma			
Osteoporosis			Prostate Cancer			
Bleeding Disease			Bleeding Disease			
Development Disorders			Development Disorders			

GI Disorder			GI Disorder			

General	Yes	No		Gastrointestinal	Yes	No
Sweats				Nausea		
Anorexia				Vomiting		
Fatigue				Diarrhea		
Weight Loss				Changes in bowel habits		
Insomnia				Abdominal Pain		

Respiratory	Yes	No		Cardiovascular	Yes	No
Cough				Chest Pains		
Difficulty Breathing				Palpitations		
Wheezing				Shortness of breath		

Skin	Yes	No	
Bruising			
Rash			
Suspicious lesions			

Office Use Only

Vitals	Weight	Height	Blood Pressure	Pulse	Temp

Staff Comments: _____

MENS CHECKLIST FOR SYMPTOMS OF HORMONE IMBALANCE

The following checklists can be used to help you and your healthcare provider determine specific symptoms of hormone imbalance.

Category 1: Basic Hormone Imbalance

Note which of the following symptoms are troublesome and/or persist over time.

___Hot Flashes
___Burned out feeling
___Apathy
___ Decreased libido
___Decreased mental sharpness
___Decreased urine flow
___Decreased stamina
___ Decreased muscle mass
___Irritability
___Insomnia
___Erectile dysfunction
___Infertility problems
___Increased urinary urge
___Night sweats
___Prostate problems
___Sleep disturbances
___Oily Skin
___Weight gain

Number selected___

Category 2: Adrenal Hormone Imbalance

Note which of the following symptoms are troublesome and/or persist over time.

___Aches and pains
___Sleep disturbance
___Infertility
___Chronic illness
___Stress
___Elevated triglycerides
___Depression
___Lack of Motivation
___Evening fatigue
___Morning fatigue
___Anxiety
___Allergic conditions
___Susceptibility to infections
___Bone loss
___Blood sugar imbalance
___Autoimmune illness
___Weight gain
___Prostate problems
___Decreased erections
___Fibromyalgia
___Susceptibility to infections

Number selected___

Category 3: Thyroid Hormone Imbalance

Note which of the following symptoms and/or persist over time.

___Cold body temperature
___Constipation
___Decreased erections
___Depression
___Elevated cholesterol
___Fatigue
___Feeling cold all the time
___Foggy thinking
___Headaches
___Inability to lose weight
___Infertility
___ Lack of motivation
___ Low libido
___Sleep disturbances

Number selected___

History Update: Have you...?

___Diagnosed Hashimotos
___Had urology work up
___Diagnosed Prostate cancer
___Activity level: low, med, high
___Do your medicines include Thyroid medicine, Propecia, Proscar or Avodart?
___Smoker