INSTRUCTIONS:

This PDF file can be downloaded to your computer or printed on your printer in order to be completed by hand and brought with you to your appointment. If you can scan the completed form, you can email it to **drjoffice@yahoo.com** . Be sure to include your full name in the body of your email.
Should you have any questions, please contact us at **325.698.8500**.

Thank You!

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USE PAGE 4 TO ADD ADDITIONAL DETAILS

MALE 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 [ ]

Surgeries [list all & when] [ ]

Other pertinent information [ ]

Medical Illnesses:

- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Hypertension
- [ ] Heart Disease
- [ ] Stroke and/or Heat Attack
- [ ] Blood Clot and/or Pulmonary Embolism
- [ ] Arrhythmia
- [ ] Any form of Hepatitis or HIV
- [ ] Lupus or any other Auto-Immune Disease
- [ ] Fibromyalgia
- [ ] Trouble passing Urine or take Flomax or Arodart
- [ ] Chronic Liver Disease [Hepatitis/Fatty Liver/Cirrhosis]
- [ ] Diabetes
- [ ] Thyroid Disease
- [ ] Arthritis
- [ ] Depression / Anxiety
- [ ] Testicular or Prostate Cancer
- [ ] Elivated PSA
- [ ] Prostate Enlargement
- [ ] Cancer [type] [ ] [year] [ ]
- [ ] Other [ ]

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	Signature	Today's Date

HEALTH ASSESSMENT FOR MEN

Name [ ] Date [ ]

Email [ ]

SYMPTOMS [please check box]	**Never**	**Mild**	**Moderate**	**Severe**
1] Fatigue	☐	☐	☐	☐
2] Mood Changes				
Irritibiity	☐	☐	☐	☐
Anxiety / Nervousness	☐	☐	☐	☐
Depression				
3] Decreased Mental Ability	☐	☐	☐	☐
Memory Loss				
Confusion	☐	☐	☐	☐
Loss of Focus				
4] Excessive Sweating	☐	☐	☐	☐
5] Weight Gain				
Bloating	☐	☐	☐	☐
Excessive Belly Fat				
Inability to Lose Weight	☐	☐	☐	☐
6] Decreased Sex Drive				
No Morning Erections	☐	☐	☐	☐
7] Sleep Problems				
Can't Stay Asleep	☐	☐	☐	☐
Can't Fall Asleep				
8] Decreased Muscle Strength	☐	☐	☐	☐
9] Hair Loss / Breakage				
10] Joint Pain / Muscle Aches	☐	☐	☐	☐

FAMILY HISTORY [please check box]	**NO**	**YES**
Heart Disease	☐	☐
Diabetes	☐	☐
Osteoporosis	☐	☐
Alzheimer's Disease	☐	☐
Prostate Cancer	☐	☐

USE PAGE 4 TO ADD ADDITIONAL DETAILS

MALE PATIENT QUESTIONNAIRE & HISTORY

Name [Last] [First] [Middle] ☐ Today's Date ☐

Date of Birth ☐ Age ☐ Weight ☐ Occupation ☐

Home Address ☐

City / State / Zip ☐

Home Phone ☐ Cell Phone ☐ Work ☐

Email Address ☐ May we contact you via Email? ☐ YES ☐ NO

In Case of Emergency Contact ☐ Relationship ☐

Home Phone ☐ Cell Phone ☐ Work ☐

Primary Physician's Name ☐ Phone ☐

Address/City/State/Zip ☐

Marital Status [Check One] ☐ Married ☐ Divorced ☐ Widower ☐ 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 to your spouse or significant other about your treatment.

Spouse's/Significant Other's Name ☐ Relationship ☐

Home PHone ☐ Cell Phone ☐ Work ☐

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.

ADDITIONAL DETAILS