APOLLO MEDICAL ASSOCIATES

**Male Patient Questionnaire & History**

Name: _____Today's Date: _____

(Last) (First) (Middle)

Date of Birth: _____ Age: _____ Weight: _____ Occupation: _____

Home Address: _____

City: _____State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

E-Mail Address: _____May we contact you via E-Mail? ( ) YES ( ) NO

In Case of Emergency Contact: _____ Relationship: _____

Home Phone: _____Cell Phone: _____Work: _____

Primary Care Physician's Name: _____Phone: _____

Address: _____

Address City State Zip

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: _____

**Social:**

( ) I am sexually active.

( ) I am not sexually active.

( ) I want to be sexually active.

( ) I have completed my family.

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

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**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:**

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 and when: _____

Other Pertinent Information: _____

_____

**Medical Illnesses:**

( ) High blood pressure.
( ) High cholesterol.
( ) Heart disease.
( ) Stroke and/or heart attack.
( ) Blood dot 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.

**BHRT Checklist for Men**

Name: _____ Date: _____

E-Mail: _____

**Please check mark:**

| Symptom | Never | Mild | Moderate | Severe |
|---|---|---|---|---|
| Depressive mood | | | | |
| Fatigue | | | | |
| Memory Loss | | | | |
| Mental confusion | | | | |
| Decreased sex drive/libido | | | | |
| Sleep problems | | | | |
| Mood changes/Irritability | | | | |
| Tension | | | | |

| | | | | |
|---|---|---|---|---|
| Migraine/severe headaches | | | | |
| Difficult to climax sexually | | | | |
| Bloating | | | | |
| Weight gain | | | | |
| Breast tenderness | | | | |
| Hot flashes | | | | |
| Night sweats | | | | |
| Dry and Wrinkled Skin | | | | |
| Hair is Falling Out | | | | |
| Cold all the time | | | | |
| Swelling all over the body | | | | |
| Joint pain | | | | |

**Family History:**

| | **NO** | **YES** |
|---|---|---|
| Heart Disease | | |
| Diabetes | | |
| Osteoporosis | | |
| Alzheimer's Disease | | |
| Breast Cancer | | |