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Male Medical History

Name: ______________________________ DOB: _______________

Habits:

( ) Smoke cigarettes or cigars ______ per day
( ) I drink alcoholic beverages:
Amount: _______ Per Day _______
Per Week _______ Per Month ________
( ) Amount of coffee: ______
( ) Amount of soda _____ per day.
( ) Energy drinks _____ per day.
( ) Exercise ____ times a week.

Your Family Medical History:

( ) Arthritis, Gout
( ) Asthma, Hay Fever
( ) Cancer (type):_________________________
( ) Chemical Dependency
( ) Diabetes
( ) Heart Disease, Strokes
( ) High Blood Pressure
( ) Kidney Disease
( ) Anxiety/Depression
( ) Other
____

Your Medical Illnesses:

( ) High blood pressure.
( ) High cholesterol.
( ) Heart Disease.
( ) Stroke and/or heart attack.
( ) Blood clot and/or a pulmonary emboli.
( ) 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.
( ) Depression/anxiety.
( ) Other: ___________________________________
( ) Cancer (type): _____________________________
Year: _____________

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: ____

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