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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: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_