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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: _____

_____

_____