306 South Park Avenue, Winter Park, FL 32789 Telephone: (407)-644-1025 Fax: (407)-644-0160

Men's Health Education Form

Date: _____

Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Occupation: _____

Physician: _____
Office Address: _____
Office Phone Number: _____

Medication Allergies: _____
Other Allergies:_____

Current Prescription Medications/Hormones:
_____
_____

Non–Prescription Medications/Vitamins:
_____
_____

Hormones used in the past: _____

Medical Conditions and/or Diseases diagnosed by your physician:_____

Testosterone Levels (total/free): _____/_____ LH: _____ FSH: _____ TSH: _____

Height: _____ Weight:_____ Age: _____

Why are you here today? _____
_____
_____

Referred by: _____

PHARMACY NOTES: _____

Please answer the following questions:

Do you have trouble remembering?	Yes / No / At Times
Do you have trouble concentrating?	Yes / No / At Times
Do you feel a lack of pleasure in life?	Yes / No / At Times
Do you feel withdrawn or shy?	Yes / No / At Times
Do you feel nervous or anxious?	Yes / No / At Times
Do you feel depressed?	Yes / No / At Times
Do you have mood swings?	Yes / No If yes, how often? _____
Do you become angry easily?	Yes / No / At Times
Do you have a decreased desire for sex?	Yes / No / At Times
Do you have difficulty keeping an erection?	Yes / No / At Times
Do you have decreased spontaneous erections?	Yes / No / At Times
Do you have decreased intensity of orgasm?	Yes / No / At Times
Do you have trouble urinating?	Yes / No / At Times
Do you wake up several times a night to urinate?	Yes / No / At Times
Do you have prostate enlargement / cancer?	Yes / No
Do you have hair loss?	Yes / No If yes, when did it start? _____
Do you have body hair loss?	Yes / No
Have you has a decrease in shaving frequency?	Yes / No
Is your skin unusually dry?	Yes / No
Is your skin thinning?	Yes / No
Have you noticed slow wound healing?	Yes / No
Do you have joint pain?	Yes / No / At Times
Do you have osteoporosis and/or bone fracture?	Yes / No
Do you crave carbohydrate foods?	Yes / No / At Times
Do you crave sweet foods?	Yes / No / At Times
Do you crave salty foods?	Yes / No / At Times

Do you drink soda?	Yes / No	If yes, how many per day? _____
Do you smoke?	Yes / No	If yes, how many packs per day? __
Do drink alcohol?	Yes / No	If yes, how many a week? _____
Are you experiencing any recent weight gain?	Yes / No	
Are you experiencing any recent weight loss?	Yes / No	
Do you exercise?	Yes / No	If yes, how often per week? _____
Do you fatigue easily?	Yes / No	
Do you have muscle weakness?	Yes / No	
Do you have decreased muscle mass?	Yes / No	
Do you have high blood pressure?	Yes / No	
Is there heart disease in the family?	Yes / No / NA	If yes, who? _____
Is there a history of cancer in the family?	Yes / No / NA	If yes, who? _____

Additional history and comments:

_____

_____

_____

_____

_____

_____

_____