

Health History Questionnaire

Patient Name _____ Date _____ Age _____

Occupation _____

SYMPTOMS OF LOW TESTOSTERONE LEVELS

- Decreased Energy ___Yes ___No
 Increased Fatigue ___Yes ___No
 Muscle Weakness ___Yes ___No
 Decrease in Libido ___Yes ___No
 Erectile Dysfunction ___Yes ___No
 Decreased Attention ___Yes ___No
 Memory Loss ___Yes ___No
 Moodiness ___Yes ___No
 Depression ___Yes ___No
 Feeling Unmotivated ___Yes ___No
 Poor Sleep Habits ___Yes ___No
 Weight Gain ___Yes ___No
 Decreased Concentration ___Yes ___No

PERSONAL HEALTH HISTORY

PLEASE  CIRCLE ALL THAT APPLY

General: fainting abnormal weight loss depression cancer

Cardiac/Vascular: chest pain congestive heart failure high blood pressure peripheral vascular disease blood clots selling heart disease high cholesterol diabetes mellitus

Respiratory: difficulty breathing allergy bronchitis pneumonia asthma sleep apnea hay fever

Gastrointestinal: diarrhea intolerance to milk products constipation gallbladder disease gall stones liver disease cirrhosis

Genitourinary: change in urinary frequency over active bladder incomplete emptying of bladder on/off urinary stream pain with urination burning sensation with urination infection of kidney urinary tract infection blood in urine prostate enlargement(BPH) prostate cancer

Previous Therapy: had testosterone levels checked used testosterone previously if so for how long

_____ What type? _____ Amount and frequency? _____ When was last dose? _____

Used estrogen blockers HCG

Primary Care Provider _____ Date of last visit _____

Surgical/ Procedure History:

Year _____ Procedure/Reason _____

Year _____ Procedure/Reason _____

SOCIAL HISTORY

Smoking/Tobacco: not smoking current every day smoker cigarettes chew cigars

Alcohol: yes no number of drinks per week _____

Drug Use: yes no

Exercise Habits: Sedentary (no exercise) Mild Exercise Occasional Vigorous Exercise Regular vigorous exercise

Describe type of exercise and frequency (resistance training, cardiovascular, number of times per week, etc.,)

Family History: Any family history of prostate cancer? Yes ___ No ___

List your prescribed drugs *and* any over-the-counter drugs, such as vitamins and including pre-work-out supplements, herbals, inhalers:

Drug Name _____ Dosage _____ Frequency _____ Taken For _____

Drug Name _____ Dosage _____ Frequency _____ Taken For _____

Drug Name _____ Dosage _____ Frequency _____ Taken For _____

Drug Name _____ Dosage _____ Frequency _____ Taken For _____

Allergies: _____ No Known Allergies

Or, List Allergies and Reaction _____

Signature _____ **Date** _____

Name (Print) _____

