New Patient Medical History (Male)

Allergies

Please list any allergies to medications (or latex) that you may have. What type of reaction?

Past Medical History

Please select the box if you have had one of these:

- High blood pressure
- Heart disease
- Diabetes
- Asthma or Lung disease
- Stomach/Intestinal disease
- Kidney disease
- Liver disease
- Anemia
- Breast disease
- Lupus or autoimmune disease
- Thyroid disease
- Seizures or epilepsy history
- Neurologic problems
- Cancer
- History of trauma / car accident
- Blood clots
- Depression
- Schizophrenia / Bipolar Disorder
- Eating Disorder
- Chicken pox
- Other

If you have selected any of the boxes, enter details below:

Past Surgical History

List Year/Surgery

Hospitalizations

If you have been hospitalized for any reason (excluding surgeries listed above and deliveries), please describe here:

Medications

Please list your current medications, including vitamins and herbs, and their respective doses:

Family History

Has anyone in your family had the following?

- High blood pressure
- Diabetes
- Heart Disease
- Breast Cancer
- Ovarian Cancer
- Colon Cancer
- Other Cancer
- Other

If you chose any of the previous options, please describe the condition and the family member's relationship to you:

Social History

Occupation or Training:

Marital Status:

If married, number of years married:

Exercise type and Frequency:

Caffeine Intake:

Dairy Intake:

Fruits and Vegetables:

Gluten intake:

Have you used any of the following?

Alcohol

If yes, servings/day and type

Tobacco

If yes, how much or how many packs per day, and how many years have you been smoking?

Recreational drugs:	Heroin Cocaine Marijuana Methampetamines Narcotics/Opioids Sleeping pills Other

If checked, please describe below:

Health Maintenance

Have you ever had the following?	**Colonoscopy** **Cholesterol screening** **Thyroid testing** **Stool Blood testing** **Sigmoidoscopy** *For each option chosen above, please enter the date each test was taken and its result below.*

Review of Systems

Check any of the following that you are **CURRENTLY** experiencing:

General	Weight loss
	Weight gain
	Fatigue
	Night sweats
	Change in strength or exercise tolerance
Skin	Rash
	Bothersome hair growth
	Hair loss
	Itching
	Dry skin
Head, Eyes, Ears, Nose and Throat	Headaches
	Changes in vision
	Excessive tearing
	Changes in hearing
	Ringing in ears
	Dizziness or vertigo
	Nosebleeds
	Difficulty swallowing
	Bleeding gums
	Neck pain
Breast	New lumps
	Nipple discharge
	Tenderness or swelling
Chest	Shortness of breath
	Wheezing
	Cough
Cardiovascular	Chest pains
	Heart palpitations
	Fainting
	Swelling
	Dizziness

Gastrointestinal	Nausea
	Vomiting
	Constipation
	Diarrhea
	Bloody stools
	Black tarry stools
	Change in appetite
	Abdominal pain
Genitourinary	Pain with urination
	Frequent urination at night
	Blood in urine
	Vaginal discharge
	Vaginal itching
	Joint or muscle pain
Have you ever had a sexually transmitted infection?	None
	HPV (Human Papilloma Virus)
	Chlamydia
	Gonorrhea
	Syphilis
	HIV
	Hepatitis
	Genital warts
	PID (pelvic inflammatory disease)
	Trichomonas
	Other – *please describe below:*

<u>Prior Fertility Testing</u>

How long have you been trying to achieve?	
Prior investigations	Hormonal lab tests
	Semen Analysis
	Surgery

Other – *describe tests, dates, and results below:*