Ageless Men's Health

DATE:_____

CHART#_____

NAME:_____

HEALTH HISTORY QUESTIONNAIRE

Primary Care Doctor (PCP):	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

PAST MEDICAL HISTORY: **CIRCLE ALL THAT APPLY**

Cardiovascular disease: chest pain/heart failure/murmur/vascular disease/blood clots/fainting/ lower extremity edema
Respiratory disease: shortness of breath/asthma/bronchitis/pneumonia/allergies/hay fever
Gastrointestinal disease: lactose intolerance/gallbladder/gall stones/diarrhea/constipation
Genitourinary disease: overactive bladder/frequent urination/painful urination/difficult urination/ prostate enlargement/BPH
Diabetes/High Blood Pressure/Cancer/Depression/High Cholesterol/Sleep Apnea

Surgeries

Year	**Reason**	**Hospital**

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken
Allergies to medications	**Preferred Pharmacy**	
Name the Drug	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY

Exercise	☐ **Sedentary (No exercise)** ☐ **Mild exercise** ☐ **Occasional vigorous exercise** ☐ **Regular vigorous exercise**					
Alcohol	☐ **Yes** ☐ **No**	**Tobacco**	☐ **Yes** ☐ **No**			

PLEASE COMPLETE THE BACK OF THIS FORM

Do you feel pain or burning with urination?	☐ **Yes**	☐ **No**
Any blood in your urine?	☐ **Yes**	☐ **No**
Do you feel burning discharge from penis?	☐ **Yes**	☐ **No**
Has the force of your urination decreased?	☐ **Yes**	☐ **No**
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ **Yes**	☐ **No**
Do you have any problems emptying your bladder completely?	☐ **Yes**	☐ **No**
Any difficulty with erection or ejaculation?	☐ **Yes**	☐ **No**
Any testicle pain or swelling?	☐ **Yes**	☐ **No**
Date of last prostate and rectal exam? _____ / Date of last colonoscopy? _____		

SYMPTOMS OF LOW TESTOSTERONE LEVELS

Difficulty concentrating	☐ **Yes**	☐ **No**
Moodiness	☐ **Yes**	☐ **No**
Depression	☐ **Yes**	☐ **No**
Weight Gain	☐ **Yes**	☐ **No**
Decreasing sex drive	☐ **Yes**	☐ **No**
Increasing Fatigue	☐ **Yes**	☐ **No**
Decreasing energy	☐ **Yes**	☐ **No**
Daytime Sleepiness	☐ **Yes**	☐ **No**
Poor Sleep Habits	☐ **Yes**	☐ **No**
Erectile Dysfunction	☐ **Yes**	☐ **No**

I have received or reviewed the privacy practice notice (3 pages) for Ageless Men's Health, and understand the situations in which this practice may need to utilize or release my medical records. I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practice statement.

Ageless Men's Health will gladly file your insurance claims. You may be responsible for additional charges beyond the office visit co-pay based on your insurance policy. If you have any questions about your bill or explanation of benefits (EOB) we will be happy to assist you.

I understand periodic blood tests are necessary when receiving testosterone replacement therapy. Several insurance policies have strict requirements for blood testing. If your lab work needs to go to a specific outside location please let us know.

Each patient is expected to have a full yearly physical. If you do not have a primary care physician Ageless Men's Health will assist in locating one for you.

Do you have a living will? Y / N

Your signature constitutes your understanding of the above information.

Please sign and date this form: _____