New Patient Package

Please take time to read this carefully and answer all the questions as completely as possible.
We look forward to partnering with you to help you feel your best again.
Please bring this completed form to your initial appointment.

Patient Questionnaire & History

Name: _____ Today's Date: _____
(Last) (First) (Middle)

Date of Birth: _____ Age: _____ Occupation: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Social Security Number: _____ E-Mail Address:_____

May we contact you via E-Mail? ( ) YES ( ) NO

In Case of Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Primary Care Physician's Name: _____ Phone: _____

Address: _____
Address City State Zip

May we contact your Physician regarding your treatment at Men's Wellness Centers? ( ) YES ( ) NO

Marital Status (check one): ( ) Married ( ) Divorced ( ) Widower ( ) Living with Partner ( ) Single

Treatment Interested in (check all that apply):

( ) Total Hormone Replacement Therapy
( ) Testosterone Replacement Therapy
( ) Erectile Dysfunction
( ) Weight Loss
( ) Energy Boost

Medical History

Any known drug allergies: _____

Medications Currently Taking: _____

_____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Nutritional/Vitamin Supplements: _____

Surgeries, list all and when: _____

_____

Other Pertinent Information: _____

Medical Illnesses/ Conditions:

( ) High blood pressure.
( ) High cholesterol.
( ) Heart Disease.
( ) Stroke.
( ) Blood clot and/or a pulmonary emboli.
( ) Hemochromatosis.
( ) Depression/anxiety.
( ) Polycythemia.
( ) Cancer (type): _____
Year: _____
( ) Sleep Apnea.
( ) 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.
( ) Sickle Cell.
( ) Priapism.
( ) Peyronie's Disease.
( ) Anxiety.

Comments / Other Medical Conditions:

_____

_____

_____

_____

General Wellness Overview:

Symptoms ***(please check yes or no)***

	Yes	No
Decline in general well being		
Exhaustion/lacking vitality		
Decreased desire/libido		
Decreased morning erections		
Inability to obtain an erection		
Inability to maintain an erection		
Use of ED meds		
Ineffectiveness of ED meds		
Breast Development		
Poor sleep		
Daytime fatigue/Low energy		
Decreased motivation		
Anxiety/Irritability/ Depression		
Decreased muscle mass/ Strength		
Decreased endurance		
Weight gain		
Inability to lose weight		
Healthy diet		
Regular exercise		

Print Name **Signature** **Today's Date**