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Male Medical and Health Survey

Accurate completion of this form will assure that you receive the best possible consultation

Name: _____ Age: _____ E-mail: _____

Address: _____ City: _____ St: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Marital Status: _____ Birthdate: _____

Occupation: _____ Best Days and Times to Reach You: _____

How Did You Hear About Us-Please Be Specific: _____

Height: _____ Weight: _____ Blood Pressure: _____ Heart Rate: _____

List Illnesses and Dates: _____

List Surgeries, Hospitalizations and Dates: _____

All Allergies: _____

Personal Physician Name and Address & Phone#: _____

Please describe you major problems and/or symptoms. If none, please write your reason for seeking this consultation. Please be clear and concise to help us help you. Include when the symptoms first appeared. Write what you can in the space provided. If you need more space, add a separate sheet of paper.

HEART DISEASE RISK FACTORS

Y	N	Age Years - Male ≥ 45 Female ≥ 55 or early menopause without estrogen replacement therapy
Y	N	Family history of premature Heart Disease (definite myocardial infarction or sudden death before 55 in father / close male relative, or 65 in mother / close female relative)
Y	N	Current cigarette smoker
Y	N	Hypertension (Blood pressure $\geq 140/90$ mm Hg confirmed by measurements on several occasions or taking antihypertensive medication)
Y	N	Low HDL (good) cholesterol (<35 mg/dl confirmed by measurements on several occasions [0.9 mmo/L])
Y	N	Diabetes mellitus (sugar)
Y	N	High HDL (good) cholesterol (≥ 60 mg/dl [1.6 mmo/L])

Read carefully through the list of symptoms in each group, and put a check mark next to each symptom that you have. (If you check off the same symptom in more than one group, that's fine.)

Symptom Group 1

Weight loss _____

Loss of muscle _____

Lower sex drive _____

Fatigue _____

Enlarged breast _____

Lower stamina _____

Softer erections _____

Gallbladder problems _____

TOTAL BOXES CHECKED _____

Symptom Group 2

Hair loss _____

Prostate enlargement _____

Irritability _____

Puffiness/bloating _____

Headaches _____

Breast enlargement _____

Weight gain _____

TOTAL BOXES CHECKED _____

Symptom Group 6

Debilitating fatigue _____

Low blood pressure _____

Intolerance to exercise _____

Unstable blood sugar _____

Thin and/or dry skin _____

Foggy thinking _____

Brown spots on face _____

Date of last prostate exam? _____ Was it normal? _____

If no, explain. _____

Date of last PSA? _____ What was the value? _____

Date stools last checked for blood? _____ Was it normal? _____

If no, explain. _____

Date of last sigmoidoscopy or colonoscopy? _____ Was it normal? _____

If no, explain. _____

YOU MUST DO THIS OR YOU WILL NOT BE TREATED !!

Please attach a list of all Prescription Medications and Over-the-Counter Medications you are taking .

CC INFORMATION MUST BE CLEAR AND COMPLETE

CARD HOLDER NAME: _____

ONLY CC TYPE: MC VISA DIS

CARD #: _____

EXP: _____

BILLING ADDRESS STREET NUMBER: _____

ZIP CODE: _____

3 DIGIT CODE: _____

SIGNATURE: _____