PLEASE TAKE A MOMENT TO COMPLETE OUR MALE MEDICAL HEALTH HISTORY

Today's Date: _____

Last Name: _____ First Name: _____ MI: _____

Nick Name: _____

Date of Birth: _____ Age: _____

Street Address: _____ P.O. Box Number: _____

City: _____ State: _____ Zip Code: _____

Email address **(Please Print Legibly):**

_____

YOUR EMAIL ADDRESS IS OUR HORMONE DEPARTMENT'S PREFERRED MEANS OF CONTACTING YOU

Preferred phone number for contact: Home Number: _____ Cell: _____ Work: _____
Occupation: _____

May we send you text appointment reminders? □ Yes □ No
May we send you an email for appointment reminder information? □ Yes □ No
…for medical or additional scheduling information? □ Yes □ No
…for notifying you of our monthly specials? □ Yes □ No
May we send you regular mail? □ Yes □ No

Marital Status:
□ MARRIED □ DIVORCED □ SINGLE or NEVER MARRIED □ WIDOWED □ LIVING WITH SIGNIFICANT OTHER

Ethnicity: □ Hispanic □ Asian □ Not Hispanic or Asian

Language: □ English □ Spanish □ Other _____

In case of an **emergency**, whom should we notify?

Contact Name: _____ Relationship: _____ Number: _____

Who may we release **medical or appointment information** to?

Name: _____ Relationship: _____

Preferred Pharmacy: _____

Location: _____ Phone: _____

Preferred Lab: _____ Location: _____

Physician Name: _____ Phone: _____

How did you hear of us? (Please check all that apply):
□ Internet □ Magazine □ Newspaper□ Billboard □ Mailer □ Staff Member □ Other
□ Friend or Client _____
□ Physician: _____

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We are honored that you have chosen Allura Skin, Laser & Wellness Clinic. Please state the reasons for your visit:

_____

_____

Medical History:

Please mark if you or a family member has or has ever had any of the following conditions:

You		Condition	Family	
Y	**N**	Diabetes	**Y**	**N**
Y	**N**	Hypertension	**Y**	**N**
Y	**N**	Heart Disease	**Y**	**N**
Y	**N**	High Cholesterol	**Y**	**N**
Y	**N**	Heart Murmur	**Y**	**N**
Y	**N**	Rheumatic Fever	**Y**	**N**
Y	**N**	Atrial Fibrillation	**Y**	**N**
Y	**N**	Stroke	**Y**	**N**
Y	**N**	Bleeding Disorders	**Y**	**N**
Y	**N**	Blood Clots	**Y**	**N**
Y	**N**	Polycythemia/Hemochromatosis	**Y**	**N**
Y	**N**	Varicose Veins	**Y**	**N**
Y	**N**	Leukemia/Lymphoma/MM	**Y**	**N**
Y	**N**	Liver Disease	**Y**	**N**
Y	**N**	Hepatitis A__B__C___	**Y**	**N**
Y	**N**	HIV	**Y**	**N**
Y	**N**	Hypothyroid/Hashimoto's	**Y**	**N**
Y	**N**	Hyperthyroid/Graves' Disease	**Y**	**N**
Y	**N**	Other thyroid problems	**Y**	**N**
Y	**N**	Asthma/Emphysema/COPD	**Y**	**N**
Y	**N**	Chronic Bronchitis	**Y**	**N**
Y	**N**	Kidney Disease	**Y**	**N**
Y	**N**	Crohn's/Celiac Disease	**Y**	**N**
Y	**N**	Lactose/Gluten Intolerance	**Y**	**N**
Y	**N**	Irritable Bowel	**Y**	**N**
Y	**N**	Colon Polyps	**Y**	**N**
Y	**N**	Breast Cancer	**Y**	**N**
Y	**N**	Colon Cancer	**Y**	**N**
Y	**N**	Lung Cancer	**Y**	**N**
Y	**N**	Ovarian Cancer	**Y**	**N**
Y	**N**	Prostate Cancer	**Y**	**N**
Y	**N**	Rectal Cancer	**Y**	**N**
Y	**N**	Anxiety	**Y**	**N**
Y	**N**	Depression	**Y**	**N**
Y	**N**	Psychiatric Disorder: Bipolar	**Y**	**N**
Y	**N**	Auto Immune Disorders: Lupus	**Y**	**N**
Y	**N**	Rheumatoid Arthritis	**Y**	**N**
Y	**N**	Scleroderma	**Y**	**N**
Y	**N**	Osteopenia/Osteoporosis	**Y**	**N**
Y	**N**	Arthritis	**Y**	**N**
Y	**N**	Chronic Pain/Fibromyalgia	**Y**	**N**
Y	**N**	Alzheimer's Dementia	**Y**	**N**
Y	**N**	Multiple Sclerosis	**Y**	**N**
Y	**N**	Parkinson's	**Y**	**N**

Weight: _____ **Height:** _____

Drug Allergies and Reactions:

_____

_____

Previous Surgeries or Procedures:

_____

_____

_____

_____

_____

Hospitalizations or Treatments:

_____

_____

_____

_____

Current Medications and Doses:

_____

_____

_____

_____

_____

_____

_____

Vitamins, Supplements and Herbs:

_____

_____

Do you take Aspirin or other anti-inflammatories on a daily basis? Y ____ N ____

Social History:

Do you smoke? Y ____ N ____

If yes, number per day ____ How many years? ____

Recreational drug use? Y ____ N ____

Do you drink Alcohol? Y ____ N ____

If yes, number of drinks per week? ____

How many days per week do you exercise? ____

_____

Patient Signature **Date**

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NAME: _____ DATE: _____
DOB: _____

SYMPTOM	Y	N	SYMPTOM	Y	N	SYMPTOM	Y	N
Anxiety			Decrease in energy			Mood Swings		
Depression			Decrease in sexual desire			Muscle and/or joint pain		
Difficulty concentrating			Decrease in sexual frequency			Weight gain in recent 2 years		
Fatigue			Decrease in sexual performance			Wt loss in the previous 2-6 mo.		
Fogginess in thinking			Decrease in muscle mass			Sleep Problems		
Headaches/Migraines			Loss of motivation			Poor recovery from exercise		
Irritability			Memory Loss			Poor response to exercise		

Prostate and Testicular History:

Are you currently sexually active? Y ___ N ___

Age of 1st Intercourse:_____

Please check your sexual orientation:
__ Heterosexual __ Homosexual __ Bisexual

Have you fathered any children? Y ___ N ___
If yes, how many children? _____

Have you been treated for any Sexually Transmitted Disease? Please check all that apply:
__ Chlamydia __ Gonorrhea __ Herpes
__ Syphilis __ Warts __ Other

Have you ever been tested for HIV?
If yes, when and what were the results?
Date: _____ ___ Positive ___ Negative

Have you ever had a sperm count? Y ___ N ___
What were the results? _____

Have you ever had Testicular Cancer? Y___N ___
If yes, any treatment? _____

Have you ever been told your prostate was enlarged?
If yes, any treatment? _____

Have you ever had prostatitis or any prostate problem?

Y ___ N ___ Describe: _____

Have you ever had Prostate Cancer? Y ___ N ___

If yes, when and describe treatment:
Date: _____ Treatment: _____
_____

Have you ever had blood in your urine? Y__ N __

Do you have difficulty urinating? Y __ N __

Do you urinate frequently during the night?
Y __ N __. If yes, how many times? _____

When was your last rectal exam to check your prostate?
Date: _____

Sexual History:

Do you initiate intercourse? Y___ N ___

Do you achieve orgasm? Y ___ N ___

Is intercourse satisfying? Y ___ N ___

Do you suffer from premature ejaculation?
If yes, any treatments? _____

Do you suffer from erectile dysfunction?
If yes, any treatments? _____

Is your sex drive similar to how it was 5 years ago? Y __ N__

How often do you have intercourse per wk? __ Per month? __

Are you currently using or have used any form of Testosterone?
If yes, what type? _____

Any other concerns that you would like to discuss?
_____

_____
Patient Signature Date
_____

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Authorizations:

I authorize the release of information to/from my primary care physician or specialist if deemed necessary for the treatment.

Initial _____

I understand that my insurance company will not cover any of the procedures performed.

Initial _____

Payments for all procedures or services are to be paid at the conclusion of each visit.

Initial _____

I authorize that the above information is up to date and correct to the best of my knowledge.

Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Thank You for Completing Our Paperwork!