PATIENT REGISTRATION & HISTORY FORM

Patient Last Name: _____ First name: _____ MI: ____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: (_____) _____-_____ Work #: (_____) _____-_____ Cell #: (_____) _____-_____

DOB: ____/_____/_____ AGE: _____ Height: _____ Weight: _____

SS# _____-_____-_____ Married/Single/Divorced/Widowed

Employer: _____ Occupation: _____

Email Address: _____

Emergency Contact Name: _____

Emergency Contact #: _____

Primary Insurance: _____ Secondary Insurance: _____

ID: _____ Group#: _____ ID#: _____ Group#: _____

Name of Policy Holder: _____ Name of Policy Holder: _____

Relationship to Patient: _____Relationship to Patient: _____

Policy Holder's DOB: _____ Policy Holder's DOB: _____

How did you hear about us?

___ Walk-in ____Family/Friend ____Brochure ____Internet ___Television ____Radio

Reason for visit: _____

Symptoms Began: _____ Have you ever used anabolic steroids or boosters? ____ Yes ____ No

Overall Symptom Severity ____ Mild ____ Moderate ____ Severe

Fatigue? ____ Mild ____ Moderate ____ Severe

Lack of Energy ____ Mild ____ Moderate _____ Severe

Decreased Libido/Sex Drive? ____ Mild ____ Moderate ____ Severe

Erectile Dysfunction? ____ Mild ____ Moderate ____ Severe

Morning Erection: ____ None _____ Rarely _____ Normal

Mental Fatigue/Decrease Memory/Intellectual Performance: ___ Slight ___Moderate ___Severe

Unexplained Weight Gain? ____ Mild ____ Moderate _____ Severe If so, how much _____

Weight loss goal (if applicable) _____

Sadness/Depression/Moodiness? ____ Mild ____ Moderate ____ Severe

Decreased Muscle Size or Strength _____ Slight _____ Moderate _____ Severe

Decrease in Physical Activity: ____ Slight _____ Moderate _____ Severe

Sleep Trouble? ____ Yes _____ No Sleep Apnea? ____ Yes ____ No

Check if you have: ___ Nipple tingling/tenderness ___ Breast tissue ___ Hand/Foot swelling

Medical History-Self and/or Family (Check all that apply)

Sleep Apnea/Snoring	____ Self ___Family	Kidney Disease	____Self ___ Family
Anxiety Depression	____ Self ___Family	Obesity	____Self ___ Family
Liver Disease	____Self ___ Family	Heart Disease/Stroke	____Self ___ Family
Hypertension	____Self ___ Family	High Cholesterol	____Self ___ Family
Infertility	____Self ___ Family	HIV Positive	____Self ___ Family
Anemia	____Self ___ Family	Blood Disorder	____Self ___ Family
Diabetes Type 1 or 2	____Self ___ Family	Hemochromatosis	____Self ___ Family
Thyroid Cancer	____Self ___ Family	Prostate Cancer	____Self ___ Family
Thyroid Enlargement	____Self ___ Family	Prostate Enlargement	____Self ___ Family
Hypothyroidism	____Self ___ Family	Breast Cancer	____Self ___ Family
Hypogonadism	____Self ___ Family	ADHD	____Self ___ Family

Peripheral Arterial Disease ____Self ___ Family
Reproductive/Fertility Disorder ____Self ___ Family
Polycystic Ovarian Syndrome (PCOS) ____Self ___ Family
Chronic Lymph Node Enlargement ____Self ___ Family
Prior Testosterone replacement/exposure ____Self ___ Family

List all medications you are currently taking: _____
_____

Are you allergic to any medications, foods, or vegetable/seed oils? ___ Yes ___ No
List them: _____

Other Past Medical History/Current Medical Issues/Past Surgeries _____
_____

Other Family Medical History: _____
_____

Have you had a comprehensive physical exam in the last 12 months? _____ Yes _____ No

If 40 years old or older, have you had a prostate exam in the last 12 months? ____ Yes ____ No

Date of last DRE (Digital Rectal Exam) _____ (month/year) DRE RESULTS ____ Normal ____ Abnormal

Smoking Tobacco Use: ____ None ____ Occasional ____ Frequent _____ Daily

Opioid or Pain Medication Use: ____ None ____ Occasional ____ Frequent _____ Daily

Alcohol Use: ____ None ____ Occasional ____ Frequent _____ Daily

Recreational Drug Use: ____ None ____ Occasional ____ Frequent _____ Daily

Caffeine Use: ____ None ____ Occasional ____ Frequent _____ Daily

Do you have children? ____ Yes ____ No Do you want more children? ____ Yes____ No

What is your exercise level? ____ Sedentary _____ Occasional _____ Regular

Symptom Review:

___ Decreased Appetite
___ Night Sweats
___ Blurry/Double Vision
___ Visual Disturbances
___ Hearing Loss
___ Ringing in the Ears
___ Altered Sense of Smell
___ Acne
___ Rash
___ Shortness of Breath
___ Persistent Nonproductive Cough
___ Wheezing
___ Chest Pain/Pressure
___ Fainting Spells
___ Palpitations
___ Swallowing Difficulties
___ Heart Burn
___ Persistent Nausea
___ Vomiting
___ Abdominal Pain
___ Urinary Frequency
___ Frequent Urination at Nighttime
___ Urinary Urgency
___ Urinary Hesitation
___ Dribbling after Urination
___ Painful Urination
___ Blood in Urine
___ Dizziness
___ Frequent Headaches
___ Single Extremity Weakness
___ Intolerance Hot/Cold
___ Chronic Pain
___ Joint Pain
___ Excessive Thirst
___ Appetite Problem
___ Irritability
___ Suicidal Thoughts
___ Low Self-Esteem
___ Insomnia

Patient Signature: _____ Date: _____