Endocrine &Metabolic Health services New Patient intake form
Male Reproductive

1.Who may we thank for referring you to our clinic? .

2.What is your chief concern that you would like addressed today?

3.At what age was your low testosterone diagnosed (If applicable. Please write month & year)? .

4. What were your initial symptoms, if any ?

□ Low sex drive □ Less firm erections □ Fewer morning erections
□ Unable to ejaculate □ Ejaculate too quickly
□ Fatigue □ Breast enlargement □ Breast tenderness
□ Breast discharge □ Headaches
□ Vision changes □ change in hair growth □ mental fog
□ other symptoms:

5. Have you ever been on treatment for low testosterone? ***If yes, please write dates the medication was taken.***

□ testosterone shots □ testosterone patch □ testosterone gel
□ testosterone pellets □ other (please describe)

6. Have you ever been on treatment for erectile dysfunction?

□ Viagra □ Cialis □ Stendra □ Levitra
□ Other (please describe):

7. Have you fathered children?

a. Number of children and age of each
.
□ History of infertility or difficulty in conceiving children (you or your partner)

8. Do you have any history of the following conditions?

□ Radiation exposure □ Head trauma □ testicular inflammation
□ testicular injury □ mumps
□ autoimmune disease □ thyroid disease □ prostate cancer
□ kidney disease □ liver disease
□ HIV □ sleep apnea □ depression
□ steroid pills (for breathing) □ steroid shots (for joints)
□ Enlarged prostate □ Difficulty urinating □ Blood clots

□ Hypertension □ Heart failure □ COPD/emphysema □ Lupus
□ Bariatric surgery
□ High cholesterol □ Atrial fibrillation □ Rheumatoid arthritis □ Cancer _____ □ Anemia
□ Coronary artery disease □ Ulcerative colitis/Crohns
□ Pituitary tumor □ Fibromyalgia □ Anxiety disorder
□ Adrenal insufficiency □ Low testosterone □ Celiac disease □ Adrenal nodule
□ PCOS
□ Osteoporosis □ Hyperparathyroidism □ Kidney stones □ High calcium
□ Low vitamin D □ Chronic fatigue syndrome
□ Diabetes □ Other health conditions (please write in):

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9. Many substances can lower testosterone levels. Please check for any of the following (answers are confidential)

□ Current alcohol use over 7 drinks per week □ Current opiate pain medication or tramadol use □ Current marijuana use

10. Please answer the following questions about your sleep:

What time do you go to bed?____ What time do you get up to start the day? _____ How may times do you awaken at night?_____

11. Please check any boxes that apply to you. These questions are also related to sleep.

□ Trouble falling asleep □ Snoring □ Gasping during sleep □ Pauses in breathing □ Dry mouth

□ Drooling on pillow □ Morning headache □ Racing thoughts at night □ Fall asleep during day □ Use medication to sleep

□ I am on CPAP or BiPAP □ I've had a sleep study in the past

12. What other medications do you take? (please write in below, or bring a list of your medications to your appointment)

13. Do you have any medication allergies?

□ No known drug allergies □ I am allergic to (please list):

14. Any surgeries (please list month and year if you remember)?

15. Do you have any other symptoms?

□ Unexplained weight loss	□ Chronic cough	□ Blood in stool	□ Change in ring or shoe size
□ Unexplained weight gain	□ Coughing blood	□ Painful/difficult urination	□ Purple stretch marks
□ Cold intolerance	□ Chest pain	□ Blood in urine	□ Bruising easier
□ Heat intolerance	□ Palpitations (heart racing)	□ Urinary urgency	□ Bleeding easier
□ Eye pain	□ Swelling in your ankles	□ Hair loss	□ Muscle weakness
□ Blurry vision	□ Trouble breathing lying down	□ Itchy skin	□ Hand tremor
□ Change in hearing	□ Heartburn	□ Rash	□ Seizures
□ Snoring	□ Nausea	□ Dry Skin	□ Numbness/tingling in feet
□ Neck Pain	□ Vomiting	□ Excessive urination	□ Confusion or mental fogginess
□ Hoarseness	□ Diarrhea	□ Excessive thirst	□ Increased anxiety
□ Difficulty swallowing solids	□ Constipation	□ Excess hair growth	
□ Shortness of breath	□ Dark stool	□ Hot flashes	

Please turn over for page 3

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16. What health conditions run in the family? ***If you have multiple brothers/sisters, please indicate how many have the condition (eg: if you have 3 brothers and only one had diabetes, then write 1/3***

	Mother	Father	Sister	Brother	MGM	MGF	PGM	PGF	Mat. Aunt	Mat. Uncle	Pat. Aunt	Pat. Uncle
Diabetes	□	□	□	□	□	□	□	□	□	□	□	□
High Calcium	□	□	□	□	□	□	□	□	□	□	□	□
Kidney stone	□	□	□	□	□	□	□	□	□	□	□	□
Osteoporosis	□	□	□	□	□	□	□	□	□	□	□	□
Kidney disease	□	□	□	□	□	□	□	□	□	□	□	□
Hypothyroid	□	□	□	□	□	□	□	□	□	□	□	□
Hyperthyroid	□	□	□	□	□	□	□	□	□	□	□	□
Thyroid cancer	□	□	□	□	□	□	□	□	□	□	□	□
Thyroid Nodule	□	□	□	□	□	□	□	□	□	□	□	□
Heart attack	□	□	□	□	□	□	□	□	□	□	□	□
Stroke	□	□	□	□	□	□	□	□	□	□	□	□
Pituitary tumor	□	□	□	□	□	□	□	□	□	□	□	□
Colon cancer	□	□	□	□	□	□	□	□	□	□	□	□
Breast cancer	□	□	□	□	□	□	□	□	□	□	□	□
Ovarian cancer	□	□	□	□	□	□	□	□	□	□	□	□
Leukemia	□	□	□	□	□	□	□	□	□	□	□	□
Lymphoma	□	□	□	□	□	□	□	□	□	□	□	□
Blood clots	□	□	□	□	□	□	□	□	□	□	□	□

17. Social History

A. Alcohol use (1 drink = 5 oz wine, 12 oz beer, 1.5 oz spirit) □ Never □ less than 7 drinks/week □ 7 – 14 drinks/week □ over 14 drinks/week

B. Do you smoke? □ Never □ Former □ Current If yes, how many cigarettes per day? _____

C. Do you use recreational drugs? □ Never □ Former □ Current If yes, which drugs?

D. How many children do you have? □ None □ One □ two □ three □ four □ other _____

E. Highest level of education? □ Did not complete highschool □ highschool □ some college □ 2yr college □ 4yr college □ post-graduate

F. Occupation and employer:

Thank you for taking the time to complete this history form