Male History Form

Chief Complaint: What is the main reason for your office visit today (please describe detail)?

_____

General Medical History

Have you ever had any of the following illnesses or conditions?

			Age at Diagnosis
High blood pressure	Yes	No	_____
Diabetes	Yes	No	_____
Last HgbA1C level:_____ Do you see an Endocrinologist?	Yes	No	
High cholesterol	Yes	No	_____
Obstructive Sleep Apnea	Yes	No	_____
Low testosterone	Yes	No	_____
Prostate enlargement	Yes	No	_____
Cancer	Yes	No	_____
If yes, please specify:_____			
Did you bank sperm before cancer treatment?	Yes	No	
Heart problems (Heart attack, Angina, Bypass surgery, Angioplasty/stents)	Yes	No	
If yes, please specify:_____			
Lower limb bypass surgery	Yes	No	_____
Stroke/ carotid artery surgery	Yes	No	_____
Atrial Fibrillation	Yes	No	_____
Neck or back problems	Yes	No	_____
Pelvic fracture	Yes	No	_____
Arthritis	Yes	No	_____
Anxiety	Yes	No	_____
Depression	Yes	No	_____
Color blindness	Yes	No	_____
Liver Disease	Yes	No	_____
Lung or breathing problems	Yes	No	_____
Nervous system disease	Yes	No	_____
Thyroid disease	Yes	No	_____
Generalized viral infections (i.e. mono)	Yes	No	_____
Mumps with swelling of testicles?	Yes	No	_____
Hepatitis	Yes	No	_____
HIV	Yes	No	_____
Tuberculosis	Yes	No	_____
Sickle cell disease	Yes	No	_____
Parkinson's Disease	Yes	No	_____
Other (Please specify):_____			

Urologic History

Have you ever had:			Age at Diagnosis
Infection of the prostate	Yes	No	_____
Infection of the testicles/epididymis	Yes	No	_____
Kidney or bladder stones	Yes	No	_____
Sexually transmitted infection	Yes	No	
A. Chlamydia	Yes	No	_____
B. Gonorrhea	Yes	No	_____
C. Syphilis	Yes	No	_____
D. Herpes	Yes	No	_____
Urinary tract infection	Yes	No	_____
A fever in the past three months?	Yes	No	_____
Blood in your semen?	Yes	No	_____
Pain in your scrotum or testicles?	Yes	No	_____

Male History Form

Testicles undescended at birth? Yes No _____

Any injury to your testicles or penis? Yes No _____

List any previous treatments and surgeries (operations) and when they occurred.

Inguinal Hernia repair Surgery: Right___ Left___ Bilateral___ Mesh___ Date: _____

Cardiac Catheterization/Stent: -_____ Date: _____

Prostate Cancer Surgery: Robotic ____ Laparoscopic _____ Open _____ Date: _____

Surgeon: _____ Hospital:_____

Radiation Therapy: External Beam ___ Brachytherapy (Seeds) ____ Dual therapy____ Dates: _____

Radiation Oncologist: _____ Hospital: _____

Androgen Deprivation Therapy: _____ Dates: _____

Chemotherapy:_____ Dates: _____

Bladder Cancer Surgery: Robotic ____ Laparoscopic _____ Open _____ Date: _____

Surgeon: _____ Hospital:_____

Colon/Rectal Surgery (explain): _____Date: _____

Surgeon: _____ Hospital:_____

Kidney Transplant: ___Right___ Left Date: _____

Penile Implant: Surgeon: _____ Hospital:_____ Date: _____

Operation on penis (circumcision, other) Yes No Date: _____

If yes, please specify _____

Operation on testicles (vasectomy, vas reversal, varicocele, other) Yes No Date: _____

If yes, please specify _____

Vasectomy Yes No Date: _____

Enlarged Prostate Surgery Yes No

Other surgery Yes No

If yes, please specify_____

_____

Endocrine History

Do you have, or have you ever had:

Difficulty smelling	Yes	No
Visual problems recently	Yes	No
Do you feel your energy level is low?	Yes	No
Do you have afternoon fatigue?	Yes	No
Do you have reduced strength?	Yes	No
Do you have reduced work productivity?	Yes	No
Do you have reduced endurance?	Yes	No
Do you have muscle mass loss?	Yes	No
Do you have fat gain?	Yes	No
Do you have irritability?	Yes	No
Do you have depression symptoms?	Yes	No
Do you have confusion or short-term memory loss?	Yes	No

In your work or elsewhere, are you or have you ever been exposed to any of the following?

a. Prolonged heat	Yes	No
b. Radiation	Yes	No
c. Pesticides	Yes	No
d. Industrial solvents	Yes	No
e. Agent Orange	Yes	No
f. Dyes	Yes	No
g. Heavy metals	Yes	No
h. Plastics	Yes	No