Carlisa Family Medical & Aesthetics

Address and Contact Information

Name: _____ Date of birth: _____

MALE PATIENT QUESTIONNAIRE & HISTORY

Name: _____ Date: _____

Date of birth: _____ Age: _____ Weight: _____ Occupation: _____

Home address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work: _____

Preferred contact number: _____

May we send messages via text regarding appts to your cell? ☐ Yes ☐ No

Email address: _____ May we contact you via email? ☐ Yes ☐ No

In case of emergency contact: _____ Relationship: _____

Home phone: _____ Cell phone: _____ Work: _____

Primary care physician's name: _____ Phone: _____

Address: _____
Address / City / State / Zip

Marital status (check one): ☐ Married ☐ Divorced ☐ Widow ☐ Living with partner ☐ Single

In the event we cannot contact you by the means you have provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Name: _____ Relationship: _____

Home phone: _____ Cell phone: _____ Work: _____

Social:

☐ I am sexually active. OR ☐ I want to be sexually active. ☐ I do not want to be sexually active.

☐ I have completed my family. OR ☐ I have NOT completed my family.

☐ My sex life has suffered. OR ☐ I have not been able to have an orgasm or it is very difficult.

Habits:

☐ I smoke cigarettes or cigars ____ per day. ☐ I use e-cigarettes ____ a day. ☐ I use caffeine ____ a day.

☐ I drink alcoholic beverages ____ per week. ☐ I drink more than 10 alcoholic beverages a week.

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MALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

Drug allergies

Drug allergies: _____ If yes, please explain: _____

Have you ever had any issues with local anesthesia? ☐ Yes ☐ No Do you have a latex allergy? ☐ Yes ☐ No

Medications currently taking: _____

Current hormone replacement? ☐ Yes ☐ No If yes, what? _____

Past hormone replacement therapy: _____

Family history:

☐ Heart disease ☐ Diabetes ☐ Osteoporosis ☐ Alzheimer's/dementia ☐ Breast cancer ☐ Other_____

Pertinent medical/surgical history:

☐ Cancer (type):
Year: _____
☐ Elevated PSA
☐ Trouble passing urine
☐ Taking medicine for prostate or male-pattern balding
☐ History of anemia
☐ Vasectomy
☐ Erectile dysfunction
☐ Testicular or prostate cancer
☐ Prostate enlargement or BPH
☐ Kidney disease or decreased kidney function
☐ Frequent blood donations
☐ Non-cancerous testicular or prostate surgery
☐ Severe snoring
☐ Taking medicine for high cholesterol

Birth Control Method:

☐ Not applicable
☐ None - planning pregnancy in the next year
☐ Depend on partner's contraception
☐ Vasectomy
☐ Condoms
☐ Other: _____

Activity Level:

☐ Low – sedentary
☐ Moderate – walk/jog/workout infrequently
☐ Average – walk/jog/workout 1 to 3 times per week
☐ High – walk/jog/workout regularly 4+ times per week

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MALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

Medical history:

- ☐ High blood pressure or hypertension
- ☐ Heart disease
- ☐ Atrial fibrillation or other arrhythmia
- ☐ Blood clot and/or a pulmonary embolism
- ☐ Depression/anxiety
- ☐ Chronic liver disease (hepatitis, fatty liver, cirrhosis)
- ☐ Arthritis
- ☐ Hair thinning
- ☐ Sleep apnea
- ☐ High cholesterol
- ☐ Stroke and/or heart attack
- ☐ HIV or any type of hepatitis
- ☐ Hemochromatosis
- ☐ Psychiatric disorder
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Lupus or other autoimmune disease
- ☐ Other _____