Male New Patient Questionnaire

Patient Demographics

First Name:	Middle:	Last Name:	
Home Phone:		Cell Phone:	
Email:			SSN:
Address:			City:
State:	Zip:	Age:	Date of Birth:
Referred by:		Primary Care Physician:	
Occupation:		Employer:	

Emergency Contact Information

Name:	Relationship:
Primary Phone:	Secondary Phone:
Email:	

Reason for Visit:	Height	Weight	Blood Pressure (office use only)

Allergies (List all allergies - Food, Drug, Other)

Alabama Vein & Restoration Medspa
4721 Chace Circle
Hoover, AL 35244

www.alabamaveincenter.com
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Current Medications (List all current medications)

Drug	Dose	How Often?

Supplements (List all current supplements)

Supplement	Dose	How Often?

Symptoms of Hormonal Deficiencies (check all that apply)

	Lack Or Decreased Sex Drive
	ED: Erectile Dysfunction
	Decreased or No Ejaculation
	Loss of Morning Erections
	Insomnia
	Memory Loss/Trouble Thinking
	Loss of Motivation
	New Migraine Headaches
	Decreased Muscle Mass & Strength
	Joint Aches/Arthritis
	Lack of Energy -Fatigue
	Constipation
	Thinning Eyebrows
	Poor Immunity
	Exhausted In The Morning
	Can't Fall Asleep

	Poor Balance
	Poor Coordination
	Increased Belly Fat
	Ringing in Ears
	Thinning Hair
	Depression
	New Anxiety Attacks
	Male Breast Development
	Cold All The Time
	Generalized Swelling
	Brittle Nails
	Irritable
	Low Blood Sugar
	Stay Awake For Days
	Ache All Over

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Exercise History (Check all that apply)

	I Don't Exercise
	I Have A Physical Job
	I Exercise Daily For Minutes
	I Exercise 3 Times/Week For 50 Min or More
	I Am A Long Distance Runner
	I Lift Weights Times A Week
	Normal Activity is What I Consider Exercise

Previous Testosterone Replacement (Check all that apply)

	I Have Used Pellet T Before
	I Have Used T Gel Before
	I Have Used T Shots Before
	Other:

Past Surgeries (List year of surgery)

Year	Surgery
	Lap Band Surgery or Obesity Surgery
	Open Heart Surgery
	Joint Replacement
	Cancer Surgery
	Vasectomy

Habits (Check all that apply)

	Smoking Cigarettes Or Cigars
	I Drink More Than 10 Drinks of Alcohol/Week
	I am a Recovering Alcoholic
	I Use or Have Used Marijuana In Past Year
	I Use or Have Used Cocaine
	I Use or Have Used Anabolic Steroids
	I Use or Have Used Growth Hormone

Family History (Check all that apply)

	Prostate Cancer
	Other Cancers
	Lung Cancer
	Breast Cancer (Female)
	Breast Cancer (Male)
	Obesity
	Heart Disease
	Heart Arrhythmias
	Thyroid Disease
	Arthritis
	Autoimmune Disease
	Diabetes Type I
	Diabetes Type II
	Hemochromatosis

Preventative Medicine (Check all that apply)

	PCP Visit in Last Year
	Urologist Within Last Year
	Colonoscopy In Last 10 Years
	Prostate exam in last year

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Medical Illnesses (List year of Illness)

Year	Illness
	ADD, ADHD
	Addison's Disease
	Adrenal Fatigue
	Alcoholism, Aa, Drug Dependence
	Arthritis
	Blood Clot/Pulmonary Embolism
	BPH: Benign Prostatic Enlargement
	Cancer
	Depression/Anxiety
	Diabetes Type I
	Diabetes Type II
	Emphysema / Copd
	Fatty Liver Disease
	Glaucoma
	Heart Attack
	Hemochromatosis
	Hepatitis
	High Blood Pressure

Year	Illness
	HIV, AIDS
	Insulin Resistance
	Kidney Disease
	Manic Depression or Bipolar Disorder
	Multiple Sclerosis
	Narcolepsy
	Osteoporosis
	Past History Of Head Injuries
	Post Concussion Syndrome
	Prostate Cancer
	Restless Legs
	Schizophrenia
	Seizures or Epilepsy
	Sleep Apnea
	Stroke
	TB
	Testicular Cancer
	Leber's Optic Neuritis

	Played Contact Sports (Yes/No)

	Had a Concussion? (Yes/No)

Social History (Check all that apply)

	I Have Completed My Family
	I Am Married or in Committed Relationship
	I am Sexually Active
	I Want to be Sexually Active

Diet History (Check all that apply)

	I Eat Anything I Want
	I Don't Eat Much And Gain Weight Anyway
	I Have Gained Weight In My Abdomen
	I Eat A Balanced Diet 3 Times A Day
	I Eat 6 Small Meals A Day
	I Don't Eat Meat or Animal Products
	I Am Gluten Sensitive
	I Limit Carbohydrates
	I Eat Low Fat Diet
	High Protein Diet
	Other:

I attest that all the information I give is true.

Print Name: Signature: Date:

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Communication

Consent to Communicate

Please indicate the ways you consent for Alabama Vein & Restoration Medspa to communicate with you

	Can contact (Yes/No)	Can leave message (Yes/No)
Cell Phone		
Home Phone		
Work Phone		
Email		
Text Message		

Do we have permission to speak with spouse/partner? Yes_____ No_____

Do we have permission to leave a message with spouse/partner? Yes_____ No_____

If yes, please list name(s) and relationship _____

Print Name: Signature: Date:

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