Name:

Date:

Testosterone Pre-consultation Questionnaire

To provide you with the best care possible, we request that you provide the following information. Your answer on this form will help the doctor understand your medical conditions better and more promptly leaving more tim to discuss your questions. For NO/YES questions, please supply details about any "yes" answers

When/why did you become concerned about testosterone abnormality:

When were testosterone levels first measured (?levels?):

When testosterone was first measured had you previously taken or were taking:

prescription pain medication NO/YES :

muscle building supplements or "steroids" NO/YES :

testosterone supplements/medications NO/ YES:

Regarding sexual function

Has libido (sex drive) changed NO/YES (Describe) :

Has erectile function changed NO/YES (Describe) :

Have you used erection medications NO/YES (What? Success?):

Have you tried testosterone medications NO/YES (What? How Long? Success?):

Regarding fertility:

Do you have biological children NO/YES

Have you needed fertility assistance for pregnancy NO/YES

Are you hoping to have more children NO / YES / MAYBE?

Regarding factors that may indicate a problem that can contribute to testosterone problems have you had :

Abnormal timing or issues with puberty NO/YES:

History of undescended or twisted testicle NO/YES:

History of testicular trauma or infections: NO/YES:

History of brain trauma, concussion, or stroke: NO/YES:

History of chemotherapy or radiation therapy: NO/YES:

Issues with snoring: NO/YES:

Prior Sleep apnea evaluation: NO/YES:

Family members with low testosterone NO/YES: (Who?)

Family members with fertility problems NO/YES: (Who?)

Regarding prostate health

Have you a rectal prostate exam NO/YES: If yes, last was when?abnormal?:

Have you had PSA blood testingNO/YES: If yes, last was when? Abnormal?:

PERSONAL MEDICAL HISTORY (indicate if you have the following with YEAR OF DIAGNOSIS)

Medical Problem	Year of Diagnosis/ Details	Medical Problem	Year of Diagnosis/ Details
□ High Blood Pressure		□ Osteoporosis	
□ High Cholesterol		□ Broken Bone	
□ Heart Attack		□ Liver problems/Hepatitis	
□ Stroke		□ Bleeding Problems	
□ Atrial Fibrillation		□ Intestinal Problems	
□ Celiac Disease		□ Thyroid Problem	
□ Cancer		□ Emphysema/COPD	
□ Depression / Anxiety		□ Asthma	
□ Kidney Disease		□ Smoking	
□ Kidney Stones		□ Alcoholism	

Other Problems: _____

_____

_____

SURGICAL HISTORY (list all procedures and operations with year)

Procedure/Surgery	Year	Procedure/Surgery	Year

WOMEN- Menstrual /Pregnancy history

Age of 1st menstruation:_____ Frequency of periods:_____ Length of period: _____ Menopause age: _____

#of Pregnancies:_____ # of Live Births: _____ # of Miscarriages: _____ # of Abortions: _____

Other female problems _____

If menopausal, using / used Estrogen / Progesterone treatment: Never / Yes. Details: _____

FAMILY HISTORY	**Age**	**Age of Death**	**Cause of Death and/or Medical Problems**
Mother:			
Father:			
Brother / Sister:			
Brother / Sister:			
Brother / Sister:			
Brother / Sister:			
Child: Girl / boy			
Child: Girl / boy			
Child: Girl / boy			
Child: Girl / boy			

Name:

Date:

SOCIAL HISTORY

Tobacco Use: □ Never □ Quit (Year: ____, After using for_____yrs)

□ Current: # packs/day _____ , # of years _____

Alcohol Use: □ Never □ Quit (Year:_____)

□ Drink _#_____ drinks per day / week / month / year (please circle one)

Drug Use: □ Current □ Never □ Quit (Year:_____) What used?:_____

Have you ever used injectable (i.e. IV) recreational drugs □ Yes □ No

Marital Status: □ Married □ Single □ Separated □ Domestic Partner □ Other: _____

□ Widowed- what year? _____

Sexual Activity: Sexually active? □ Yes □ No □ Not Currently

Current partner is □ Male □ Female

Birth control method (if applicable): _____

Retired? Yes / No. Current or Past Occupation: _____

Highest level of school completed:_____

MEDICATION ALLERGIES / INTOLERANCES: □ NONE

Drug	Reaction	Drug	Reaction

CURRENT MEDICATIONS

Drug	Dose (pill size?)	Dose (amount & frequency)
□ Aspirin	□ 81mg □325 mg	□ One tab once daily □ One tab twice daily _

Current Symptom Review

Rate average energy past week (1=low, 10= high): _____/10

	Symptoms		No Problem	Issue details: circle one N =new, C = chronic. → **Please provide details /changes.**
a)	Fevers/ Sweats	a)		N / C →
b)	Intolerance of cold	b)		N / C →
c)	Intolerance of heat	c)		N / C →
d)	Vision change	d)		N / C →
e)	Sinus or ear symptoms	e)		N / C →
f)	Chest Pains	f)		N / C →
g)	Heart Racing	g)		N / C →
h)	Leg swelling (edema)	h)		N / C →
i)	Shortness of breath	i)		N / C →
j)	Cough	j)		N / C →
k)	Nausea or Vomiting	k)		N / C →
l)	Abdominal Pain	l)		N / C →
m)	Discomfort w/ urination	m)		N / C →
n)	Joint Pains	n)		N / C →
o)	Balance problems / Falls	o)		N / C →
p)	Difficulty with memory	p)		N / C →
q)	Tremor	q)		N / C →
r)	Headaches	r)		N / C →
s)	Skin rash or skin lesions	s)		N / C →
t)	Hair Loss	t)		N / C →
u)	Bleeding / Bruising	u)		N / C →
v)	Allergies	v)		N / C →
w)	Insomnia	w)		N / C →
x)	Anxiety	x)		N / C →
y)	Depression	y)		N / C →

Bowel Movements: Per day _____ OR Per week _____

Urinating at night: none OR # per night _____