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Men's Medical Institute

Testosterone Replacement Therapy

Patient Medical History Form

1. Are you in good health at the present time to the best of your knowledge? Yes No
   If no please provide explanation.

2. Are you under a doctor's care at the present time? Yes No
   If yes, for what?

3. Are you taking any medications at the present time? Yes No

Prescription or Over the Counter Medications, please list all:

Drug: Dosage

4. Do you have any allergies to any medications? Please list all:

5. History of High Blood Pressure? Yes No
6. History of Diabetes? First diagnosed at what age? Yes No
7. History of Heart Attack or Chest Pain or other heart condition? Yes No
8. History of Swelling Feet? Yes No
9. History of Sleep Apnea? Yes No
10. History of Thyroid disease? Yes No
11. History of Hormone problems or low testosterone levels? Yes No
    If yes, what and how was it treated?
12. History of BPH (Benign Prostatic Hypertrophy)or other prostate problems Yes No
13. Have you ever had trouble urinating? If yes describe: Yes No
14. History of Prostate or Breast Cancer ? Yes No
15. Family history of Prostate Cancer? Yes No
16. History of DVT or blood clots in legs or lungs? Yes No
17. History of Polycythemia?(Disease caused by your body making too many red blood cells)

    Yes No

18. History of low sperm count? Yes No
19. Are you planning to have more children? Yes No
20. Have you ever been on Testosterone Replacement Therapy before? Yes No
21. History of Liver problems? Yes No

Date of last annual physical exam:_____

Name of Primary Care Physician:_____

Date of last PSA:_____ Date of last prostate exam_____

22. Do you smoke? Yes No
23. Do you drink beer, wine or hard liquor? Yes No
    If yes, frequency_____. How many drinks_____.

Circle which best describes your exercise habits:

Sedentary (no exercise) Mild/Occasional/Regular vigorous exercise

Symptoms of Low Testosterone Levels	**Yes**	**No**
Difficulty concentrating		
Moodiness		
Depression		
Weight gain		
Decreasing sex drive		
Increasing fatigue		
Decreasing energy		
Daytime sleepiness		
Erectile dysfunction		

I have received or reviewed the Privacy Practice Notice for Men's Medical Institute, and understand the situations in which this practice may need to utilize or release my medical records. I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practice statement.

I understand periodic blood tests are necessary when receiving Testosterone Replacement Therapy.

I agree, while a patient of Men's Medical Institute, I will not take any type of anabolic steroids, testosterone gels, hormone "boosters", pro-hormones or any additional testosterone supplementation not provided by Men's Medical Institute during my treatment plan. At any time, if use of these items is discovered, I understand I may be discharged as a patient of Men's Medical Institute.

Each patient is expected to have a full yearly physical including a Prostate exam with your Primary Care Provider.

Your signature constitutes your understanding of the above information.

Please sign and date this form: _____ date: _____