# 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)

| | | |
|---|---|---|
| | | |
| | | |
| | | |
| | | |


Restoration Medicine
700 Montgomery Hwy, Ste 210
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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 Restoration Medicine 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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