

Patient Name: _____
 Date: _____



New Patient Past Medical History Form

Medications (Bring list if needed)

Name	Dose (strength, frequency)

Allergies: _____

Past surgical history... (please list operation name and date)

Have you ever been diagnosed with any of the following...

	YES	NO		YES	NO		YES	NO
Cardiac			Endocrine			Musculoskeletal		
Heart attack	___	___	Diabetes	___	___	Back pain	___	___
Congestive heart failure	___	___	Thyroid problems	___	___	Joint pain	___	___
High blood pressure	___	___	Frequent urination	___	___	Arthritis	___	___
High Cholesterol	___	___	Sensitivity to Heat or Cold	___	___	Blood Clots	___	___
Chest Pain	___	___						
			Genitourinary			Gastrointestinal		
Pulmonary			Painful Urination	___	___	Colitis	___	___
COPD	___	___	Erectile Dysfunction	___	___	Crohns	___	___
Asthma	___	___	Frequent night time urination	___	___	Chronic diarrhea	___	___
Shortness of Breath	___	___	Kidney Disease	___	___	Chronic constipation	___	___
Pulmonary Embolism	___	___	Prostate disease	___	___	Hepatitis	___	___
Sleep Apnea	___	___				Acid Reflux	___	___
			Neurological			Chronic Disease		
Psychiatric			Epilepsy	___	___	Tuberculosis	___	___
Depression	___	___	Stroke	___	___	HIV / Aids	___	___
Anxiety	___	___	Traumatic brain injury	___	___	MRSA	___	___
Bipolar	___	___	Concussion	___	___	Cancer	___	___
			Headaches	___	___			
			Dizziness	___	___			

Smoking or Vaping History:

Current: ___ Former: ___ Never: ___
 Quit Date: _____

Diet History:

Poor: ___ OK: ___ Good: ___

Testosterone Therapy History:

Have you ever been tested : ___
 When: ___
 Initial Testosterone level: ___

Alcohol History:

Social: ___ Daily: ___ Never: ___
 Drinks per Day: _____

Sleep History:

Hours per Night: _____
 Wake Feeling Rested: _____
 Do you snore: _____
 Do you stop breathing in your sleep?: _____
 Have you ever been tested for Sleep Apnea?: _____

Testosterone dose: _____
 HCG dose: _____
 Anastrozole dose: _____

Drug History:

Current: ___ Former: ___ Never: ___
 Type: _____

How long have you been on therapy: _____

Exercise History:

Cardio: ___ Lifting: ___ Both: ___
 Days per week: _____