4239 Farnam St. Suite 734 / (402) 552-2700
16909 Lakeside Hills Ct. Suite 201 / (402) 991-1900
Emergencies & After Hours / (402) 552-2700
Medical Record Fax / (402) 552-2972
Office Fax / (402) 552-2709

MALE MEDICAL HISTORY *(Please Complete Before Your Visit)*

Contact Information

Name: _____ Preferred First Name (if different): _____

Phone #: _____ *(cell # may be preferred)* OK to leave a message? _____YES _____NO

Referred by: _____ Preferred Pharmacy: _____

Other Health Care Providers (**CHECK** if you would like a note sent to your health care provider)

_____Primary Doctor: _____ _____Counselor/Therapist: _____

_____Psychiatrist: _____ _____Other: _____

Demographic Information

Are you (circle all that apply):

Single Married Widowed Committed Relationship Same Sex Relationship

Education:

Less than 12 years High school graduate Currently in school

College Degree Postgraduate degree

What is your profession/what type of work are you doing? _____

Information About Your Condition

What are your primary concerns? _____

_____

How long have you had the issues or concerns? _____

Is there an event associated with the onset of symptoms? ___No ___Yes (explain) _____

_____

What medical/nonmedical treatments have you tried? _____

_____

Medical History

✔**CHECK** all that apply:

_____Fatigue	_____Frequent urination	_____Headaches
_____Weight gain	_____Frequent urination at night	_____Difficulty focusing
_____Difficulty sleeping	_____Frequent UTIs	_____Irritability
_____High blood pressure	_____Leakage of urine	_____Anxiety
_____High cholesterol	_____Enlarged prostate	_____Depression
_____Blood clot	_____Elevated PSA level	_____Bipolar Disorder
_____Heart Attack	_____Prostate infection	
_____Stroke	_____Prostate cancer	_____Lack of sexual desire
		_____Premature ejaculation
_____Constipation	_____Diabetes	_____Delayed ejaculation
_____Diarrhea	_____Hypothyroid	_____Decreased hardness of erection
	_____Back pain	_____Difficulty achieving an erection

Other medical conditions or history of cancer: _____

_____

Have you used any of the following medications/treatments?

Medication	**Effective?** (Yes or No)	**Unwanted Side Effects or Additional Comments:**
_____Viagra		
_____Levitra		
_____Cialis		
_____Testosterone gel/cream		
_____Testosterone pellet		
_____Other: _____		

**How often do you exercise?* Rarely 1-2 Times weekly 3-5 times weekly Daily

**How many cups of caffeine per day?* (include coffee, tea, soda) 0 1-3 4-6 More than 6

**Do you smoke?* NO YES *How many cigarettes per day?* _____ *For how many years?* _____

**How often do you drink alcohol?* Never Rarely Monthly Weekly Daily

**Do you use recreational drugs?* NO YES

**How would you describe your diet?*

Well- Balanced Fried/Fast food Low Cholesterol Low Fat Other: _____

**Please list any causes of stress* (ex. finances, work, relationship) _____

**How many children do you have?* _____ *Age of children?* _____

**Have you ever been the victim of:* Verbal abuse Physical abuse Sexual abuse Rape No Answer

ALLERGIES: _____

Current Medications

Medication	Dose/Frequency	

Surgical Procedures

Year	Procedure	Year	Procedure

Family History

✔Check if you were you adopted ____ (Leave BLANK If you do not know your family history).

✔Check box if a family member has been diagnosed/treated for any of the following:

	Mom	Dad	Brother	Sister	Grandma (mom's parent)	Grandma (dad's parent)	Grandpa (mom's parent)	Grandpa (dad's parent)
Anxiety								
Depression								
Heart Disease								
High Cholesterol								
Stroke								
Breast cancer								
Ovarian cancer								
Prostate cancer								
Uterine cancer								

Additional comments or conditions not listed above: _____

_____