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Emergencies & After Hours / (402) 552-2700
Medical Record Fax / (402) 552-2972
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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:

<input type="checkbox"/> Fatigue	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Headaches
<input type="checkbox"/> Weight gain	<input type="checkbox"/> Frequent urination at night	<input type="checkbox"/> Difficulty focusing
<input type="checkbox"/> Difficulty sleeping	<input type="checkbox"/> Frequent UTIs	<input type="checkbox"/> Irritability
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Leakage of urine	<input type="checkbox"/> Anxiety
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Enlarged prostate	<input type="checkbox"/> Depression
<input type="checkbox"/> Blood clot	<input type="checkbox"/> Elevated PSA level	<input type="checkbox"/> Bipolar Disorder
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Prostate infection	
<input type="checkbox"/> Stroke	<input type="checkbox"/> Prostate cancer	<input type="checkbox"/> Lack of sexual desire
		<input type="checkbox"/> Premature ejaculation
<input type="checkbox"/> Constipation	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Delayed ejaculation
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Hypothyroid	<input type="checkbox"/> Decreased hardness of erection
	<input type="checkbox"/> Back pain	<input type="checkbox"/> 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:
<input type="checkbox"/> Viagra		
<input type="checkbox"/> Levitra		
<input type="checkbox"/> Cialis		
<input type="checkbox"/> Testosterone gel/cream		
<input type="checkbox"/> Testosterone pellet		
<input type="checkbox"/> 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: _____
