



Patient Name: _____ **Date of Birth/Age:** _____ **Date:** _____

What is the primary reason for your visit? I have an illness/injury or other concern: _____
 Consultation only Are you an established patient at this office? Y N
 Are you establishing care at this office? Y N

Please identify your primary provider (if you have one): I do not have a primary provider

Name Location

Please explain your health concern, including how long this has been a concern and the level of significance you place on the matter:

Have you been diagnosed with any chronic disease? Y N If yes, please list them here:

Current Medications:

Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____

Current Supplements:

Multiple Vitamin (Brand: _____)
Supplement: _____ Dose: _____ Frequency: _____
Supplement: _____ Dose: _____ Frequency: _____
Supplement: _____ Dose: _____ Frequency: _____
Supplement: _____ Dose: _____ Frequency: _____

Do you have drug or food allergies? Y N

Explain: _____

Smoking History:

Do you currently smoke? NO Yes: Cigarettes _____ Packs per day Cigars _____ Cigars/day Pipe _____ Times/day Vape: _____

Do you want to quit smoking? Y N

Bowel Movements:

How many bowel movements do you typically have each day: 0—1—2—more
How would you describe your recent stools?
 Solid, well formed; no strain to pass Hard; difficult to pass Loose/Diarrhea
 Foul-smelling Floating Greenish White/Clay-colored
 Use laxatives

Have you recently noticed blood on the tissue or in the water after your stool: **Y N**
Have you noticed or suspected hemorrhoids: **Y N**



Energy Level:

What has your energy level been for the past several days?
How much sleep is normal for you?

1-----5-----10 (10 is best)
4—6—8 —10 hours per night

Stress: How would you rate your current stress level:

1-----5-----10 (10 is worst)

What is the primary cause of your stress? _____

Occupation: What type of work do you do?

- | | | |
|---|---|---|
| <input type="checkbox"/> Full-time Student | <input type="checkbox"/> Part-time student | <input type="checkbox"/> Retired; How long? _____ |
| <input type="checkbox"/> Teacher/Instructor | <input type="checkbox"/> Hospitality | <input type="checkbox"/> Entertainment/Sports |
| <input type="checkbox"/> Service Industry | <input type="checkbox"/> Landscape/Pest Control | <input type="checkbox"/> Auto Repair |
| <input type="checkbox"/> Outside Sales | <input type="checkbox"/> Retail Sales | <input type="checkbox"/> Research |
| <input type="checkbox"/> Office | Type of business: _____ | |
| <input type="checkbox"/> Healthcare | Type of clinic or facility: _____ | |
| Other: _____ | | |

Social History:

Past or current alcohol use Date of last use: _____ Alcohol volume/day: _____ N/A

Alcohol Dependency Are you a recovering alcoholic? **Y** **N** (Some medications are alcohol-based)

Current recreational drug use Drugs used: _____

Prescription Drug Dependency Drug(s): _____

Do you exercise on a regular basis? **Y** **N** If yes, please describe the type and frequency of your exercise:

Hospitalizations: Age/Reason _____

Age/Reason _____

Age/Reason _____

Surgeries: Age/Reason _____

Age/Reason _____

Have you recently had any laboratory studies or imaging (x-rays, CT, MRI, UltraSound) **Y** **N**

Recent Labs: CMP CBC/Diff TSH Other: _____

Recent Imaging: X-rays CT Scan MRI Details: _____

Were any of the results concerning? Y N

The requested information on the following pages are gender specific.



Men Only

▪ Do you experience pain with urination?	Y N
▪ Have you recently noticed a discharge from your penis?	Y N
▪ Have you recently noticed a wart, growth, or sore in your genital region?	Y N
▪ If yes, have you ever been evaluated for or diagnosed with a sexually transmitted infection?	Y N
▪ Do you have any difficulty beginning or maintaining a stream of urine?	Y N
▪ Do you frequently need to get up during sleep to urinate?	Y N
▪ Have you recently noticed blood in your urine?	Y N
▪ Are you satisfied with the currently flow of urine?	Y N
▪ Have you ever been evaluated for, or diagnosed with: ___BPH ___Prostate Cancer	Y N
▪ Do you have difficulties achieving or maintaining an erection?	Y N
▪ Do you have difficulties achieving climax?	Y N
▪ Do you think or say things such as "I've lost my mojo" or "I don't have the drive I used to have?"	Y N
▪ Do you find that you are constantly fatigued?	Y N
▪ Do you have low sex drive/libido?	Y N
▪ Are you sometimes depressed?	Y N
▪ Do you have anxiety, or are you easily agitated?	Y N
▪ Have you been diagnosed with, or wondered about, low testosterone?	Y N
▪ Have you ever noticed blood in your stool?	Y N
▪ Have you ever had a colonoscopy? If yes, date of most recent exam:	Y N

Patient Acknowledgment: _____
(Signature) (Date)

