Name: Today’s Date:   
 *(Last) (First) (Middle)*

Date of Birth: Age: Occupation:

Home Address:

City: State: Zip:

Home Phone: Cell Phone: Work:

Email Address:

How did you hear about us? ☐ Patient (Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) ☐ Event (\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

☐ Practitioner (Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) ☐ Pharmacy (Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

☐ Social Media (Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) ☐ TV (Station:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) ☐ Radio (Station:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

In Case of Emergency Contact: Relationship:

Home Phone: Cell Phone: Work:

Pharmacy Name: Phone:

Address:

Primary Care Physician’s Name: Phone:

Address:

May we share your clinical information with your PCP? ☐ Yes ☐ No

**MEDICAL HISTORY**

Weight: Have you ever had any issues with anesthesia? ( ) Yes ( ) No   
Any known drug allergies: ( ) Yes ( ) No If yes please explain:

Do you smoke? ( ) Yes ( ) No ( ) Quit How much? How often? Age started?   
Do you drink alcohol? ( ) Yes ( ) No ( ) Quit How much? How often? Age started?   
Current Medications and dosage:

Nutritional/Vitamin Supplements:

Current Hormone Replacement Therapy: Past HRT:

Surgeries, list all and when:

Other Pertinent Information:

Do you have a family history of? ( ) Heart Disease ( ) Cancer ( ) Diabetes ( ) Other

( ) Hemochromatosis  
( ) Depression / anxiety  
( ) Psychiatric disorder  
( ) Diabetes  
( ) Thyroid disease  
( ) Arthritis

( ) Trouble passing urine or take Flomax or Avodart  
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis)

( ) Prostate enlargement  
( ) Elevated PSA  
( ) Cancer:

( ) Testicular or prostate Year:

( ) Other: Year:

( ) High blood pressure  
( ) High cholesterol  
( ) Heart disease  
( ) Stroke  
( ) Heart attack  
( ) Blood clot or pulmonary emboli

*I understand that if I begin testosterone replacement with any testosterone treatment, including testosterone pellets, I will produce less testosterone from my testicles. And if I stop testosterone replacement I may experience a temporary decrease in my testosterone production. Testosterone pellets should be completely out of your system in 12 months.*

**PRINT NAME SIGNATURE DATE**