

999 Whitlock Ave Suite 11 Marietta, GA 30064

Today's	Date:	
---------	-------	--

## **New Patient Information Form**

Please print clearly. Please complete ALL information on the form before your visit today. This allows our doctor to familiarize herself with your case and do any needed research before your visit. Once filled out, please fax it to us at: 770-590-9997 (If there is sufficient time, you can mail it as well.)

mail it as well.)					
Personal Information					
First Name:	Mido	lle Initial:	Last Nam	e:	
Address:					
City:		State:		Zip:	
Cell:	Home:	<u> </u>	V-11-2-11-11-11-11-11-11-11-11-11-11-11-1	_Work:	
Email address:					
Date of Birth:Age	e: Sex	x:Male	Female	Height: _	Weight:
Occupation:		Emplo	yer:	·	
If patient is a minor, parent/g	guardian nar	me(s):			
Emergency Contact Name:					
Referred By (How did you hea	ar about us?	?):			
Financial Information					
Person responsible for payme	ent:S	elfOther	If other, I	Name:	
Method of Payment:Cash	nCheck	Visa/Mas	ter Card/[	Discover/A	merican Express
Health History					
List any major illnesses or inju	uries with ap	oproximate date	es:		
Illness or Injury	<u>Date</u> <u>C</u>	Complications	or Comr	nents	Full Recovery
	( <del></del>				
		college of the colleg			
				***************************************	
	01 <sup>-1</sup>				
			W		

## MALE HEALTH HISTORY QUESTIONNAIRE

Name	ALLE CONTROL OF THE STATE OF TH		Age:	Today's date:
Birth Date:	Weight:	Height:	Occupation:	
What is the reason for	or this visit?			
List medications you	-			
3. Any known drug allei	rgies?	candia.		
4. Do you or have you u	77			osage?
				plements you are currently taking:
6. List any significant h	ealth issues (diab	etes, surgeries, hea	rt disease, etc.)	
7. What was the date o	f your last physica	al exam?		

LIFESTYLE INDICATORS	<= less than >= greater than						
1. Do you use any of the	1. Do you use any of the following? (circle responses)						
Alcohol	None	<2 drinks/day	>2 drinks/day				
Coffee	None	<2 cups/day	>2 cups/day				
Soda	None	<2 cans/day	>2 cans/day				
Sweets/refined ca	rbs	<twice day<="" td=""><td>&gt;twice/day</td></twice>	>twice/day				
Do you smoke cigarettes/cigars or use nicotine gum? Yes No When/How often?			When/How often?				
3. How would you rate yo	ur stress level? (1:	=Low, 10=Extreme) 1	2 3 4 5 6 7 8 9 10				
4. How would you rate yo	ur stress handling?	(1=Poor, 10=Excellent)	1 2 3 4 5 6 7 8 9 10				
5. How often do you exer	cise? never	rarely sometimes	s regularly competitively				

Have you had a vasectomy? Yes No     Have you had a reverse vasectomy? Yes No	When?
Have you experienced symptoms related to the vasectomy?  Explain:	
Do you have a history of prostate problems? Yes No  Explain:	
Date of last Prostate Exam Date Date	

SL	EEP HABITS				
1.	How do you sleep?	Well	Trouble falling asleep	Trouble staying asleep	Insomnia
	How long has this	been happenir	ng?		
2.	How many hours do yo	u sleep a night	on average?		
3.	Do night sweats wake	you up? Yes	No How often?		1
4.	Do you wake up tired?	Yes No	How long has this been happ	ening?	
5.	Is your room completel	y dark when yo	u sleep at night? (no night light	t, street lamp, TV, etc.) Yes	No
6.	Do you get at least 30	minutes of outs	ide daylight time, several days	each week? Yes No	

SIGNS & SYMPTOMS	MILD	MODERATE	SEVERE	ADDITIONAL COMMENTS
Low mood / Depression				
Irritability				
Anxiety				
Anger / Aggression				
Discouragement / Pessimism				
Decreased interest in activities / relationships				
Decreased initiative / motivation / drive				
Decreased productivity at work				
Concentration problems				
Memory problems				
Foggy thinking				
Increased fatigue				
Decrease in strength / stamina				
Decrease in athletic performance				
Decreased lean muscle mass				
Muscle soreness / weakness				
Body / joint aches				
Weight loss				
Weight gain	<del>                                     </del>			
Increased fat on hips / breasts / thighs		1		
Low blood sugar / hypoglycemia		<del>                                     </del>		
Sweet cravings (carbs/chocolate)	<del>                                     </del>			
Caffeine/Stimulant cravings				
Salt cravings				
Constant hunger				
Elevated cholesterol				
Elevated blood pressure				
Digestive problems		-		
Head hair loss	+			
Need to shave less frequently	$\vdash$	1		
Body hair loss				4
Dry skin / thinning skin				
Decreased spontaneous				
morning erections				
Lowered Libido				
Erectile Dysfunction (ED)				
Pain with ejaculation				
Frequent need to urinate				
Urination is delayed/strained/incomplete				
Pain with urination				
Blood in the urine				
Bone loss/osteoporosis				
Other	and a suppose that			