Mabry Medical
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CONFIDENTIAL MEN'S HEALTH MEDICAL HISTORY FORM

WE REALIZE THIS MEDICAL HISTORY FORM IS SOMEWHAT LONG. HOWEVER, IT IS ABSOLUTELY NECESSARY FOR US TO EVALUATE YOUR GENERAL HEALTH AND SAFELY AND LEGITIMATELY PRESCRIBE THE MEDICATIONS YOU WANT AND NEED. MAKE SURE TO TAKE A FEW MINUTES TO CAREFULLY AND COMPLETELY ANSWER EVERY QUESTION. FAILING TO DO SO WILL PREVENT US FROM HELPING YOU, AS DOING SO COULD POSSIBLY JEOPARDIZE YOUR HEALTH. DO THE BEST YOU CAN—WE WILL FOLLOW-UP WITH ANY QUESTIONS WE MAY HAVE. REMEMBER, THIS INFORMATION IS COMPLETELY CONFIDENTIAL.

Please initial here that you have read the above statement: _____

I am a ò NEW or ò ESTABLISHED patient (check one).		
First Name	Middle Name	Last Name

Address	City	State	ZIP

Shipping address (if different than address above)

Home Phone	Mobile	Work

Pharmacy	Address	Phone

Medical Insurance Provider	Member ID

Prescription Insurance Provider	Member ID

	Yes	No
Have you had a complete physical examination in the past 5 years?	ò	ò
What were the results of that exam?		
Will you have a copy of that report and any labs sent to us (mail or FAX)?	ò	ò
(FOR OVER 40) Did you have your prostate examined? was it normal? ò yes ò no	ò	ò
(FOR OVER 40) Did you have your PSA checked? If yes was it normal? ò yes ò no	ò	ò
Do you regularly self examine your testicles?	ò	ò

PAST MEDICAL HISTORY

Please indicate if you now have, or have EVER had

	Yes	No
Anemia	ò	ò
Arthritis	ò	ò
Asthma	ò	ò
Blood disease	ò	ò
Bronchitis	ò	ò
Diabetes	ò	ò
Emphysema	ò	ò
Epilepsy	ò	ò
Gout	ò	ò
Hepatitis	ò	ò
Heart disease	ò	ò
High blood pressure	ò	ò
High cholesterol	ò	ò

	Yes	No
Kidney disease	ò	ò
Migraines	ò	ò
Mononucleosis	ò	ò
Pneumonia	ò	ò
Psychological problems	ò	ò
Rheumatic fever	ò	ò
Seizures	ò	ò
Stroke	ò	ò
Thyroid disease	ò	ò
TB	ò	ò
Ulcers	ò	ò
Urinary tract infections	ò	ò
Ever had any form of cancer?	ò	ò

If so, please detail:_____

PAST SURGICAL HISTORY

What surgeries have you had

	Yes	No
Appendectomy	ò	ò
Cholecystectomy (gallbladder removal)	ò	ò
Mastectomy (removal of breast tissue)	ò	ò
Tonsillectomy	ò	ò
Prostatectomy	ò	ò
Hernia repair	ò	ò
Other surgeries (please explain below)	ò	ò
Have you ever been hospitalized?	ò	ò

FAMILY MEDICAL HISTORY

Have your brothers and/or sisters, parents or grandparents, ever had (please tell which family member(s)?

	Yes	No	If yes explain who.
Heart attack	ò	ò	
Diabetes	ò	ò	
Kidney disease	ò	ò	
Leukemia	ò	ò	
Mental disorders	ò	ò	

(Family history continued)	Yes	No	If yes explain who.
Stroke	ò	ò	
Prostate cancer	ò	ò	
Other cancer	ò	ò	

Please detail ANY of the above:

	Yes	No	
Are you allergic to anything?	ò	ò	If yes, what?
Do you smoke?	ò	ò	If so, how much each day and how long have you smoked?
Do you drink alcohol?	ò	ò	How many drinks do you typically have in a week?
Do you use any illicit substances?	ò	ò	If so, which ones?

REVIEW OF SYSTEMS

Do you CURRENTLY have (please check)

	Yes		Yes		Yes
Headaches	ò	Allergy problems	ò	Short of breath	ò
Vision changes	ò	Bloody noses	ò	Chest pain	ò
Hearing changes	ò	Chronic cough	ò	Dizziness	ò
Chronic sinusitis	ò	Spitting up blood	ò	Heart failure	ò
Palpitations	ò	Arrhythmia	ò	Heart murmur	ò
Constipation	ò	Recurring diarrhea	ò	Gallbladder problems	ò
Throw up blood	ò	Bloody Stools	ò	Hernia	ò
Loss of appetite	ò	Indigestion	ò	Nausea	ò
Vomiting	ò	Jaundice (yellow skin)	ò	Abdominal pain	ò
Pancreatitis	ò	Difficult urination	ò	Pain urination	ò

Bloody urine	ò	Ever had an STD	ò	Tingling fingers or toes	ò
Acne	ò	Ever pass out	ò	Cold intolerance	ò
Bruise easily	ò	Depression	ò	Anxiety	ò
Less sexual potency	ò	Sleep problems	ò	Muscle aches	ò
Joint pain	ò	Back pain	ò	Fatigue	ò
Lethargy	ò	Nocturnal emissions	ò	Sensitive nipples	ò
Hair Loss	ò	Loss of appetite	ò	Unexplained weight loss	ò

GENERAL

Do you consider yourself to be in good health? ò Yes ò No

- ❏ If you checked no why?_____

Do you sleep well?

- ❏ Average hours of sleep per night:_____ Hours.
  - ❏ Do you sleep through the night? ò Yes ò No
  - ❏ How many times do you awaken? _____ times
  - ❏ Why do you think you wake up?_____
  - ❏ What do you do when you wake up?_____
  - ❏ Is it easy to get back to sleep? ò Yes ò No
    - ❏ How do you do to get back to sleep?_____

How much water do you usually drink each day?_____

Tell me about your diet (Details please)

Breakfast:
Lunch:
Dinner:

MEDICATIONS

Do you take any prescription medications? If yes give details below

Medication	Dose	When do you take it?

SUPPLEMENTS

What do you take each day?(vitamins, minerals, neutraceuticals, etc. List all with amounts or dosages)

Supplement	Dose	When do you take it?

Hormone Replacement Therapy

	Yes	No
Do you plan on having more children?	ò	ò
Do you have a decrease in sex drive?	ò	ò
If the answer to #151 is “YES”, is this affecting your relationship?	ò	ò
Has your strength or endurance decreased?	ò	ò
Are you enjoying life less?	ò	ò
Are you sad or grumpy?	ò	ò
Are your erections less strong?	ò	ò

(HRT questions continued)	Yes	No
Has your work performance decreased?	ò	ò
Do you have a hard time recovering from physical activity?	ò	ò
Do you have a hard time recovering from physical activity?	ò	ò
Have you ever been on HRT before?	ò	ò

CONGRATULATIONS! YOU ARE (FINALLY!) DONE WITH THIS FORM.

I HAVE COMPLETED THE MEDICAL HISTORY FORM TO THE BEST OF MY KNOWLEDGE. BY SIGNING, I CERTIFY THAT MY ANSWERS ARE COMPLETE, HONEST AND TRUE.

Signed: _____ Date: _____/_____/_____.