hopkins
DERMATOLOGY

MALE PATIENT INFORMATION

Name: ______________________________ Today's Date: MM/DD/YYYY ______
LAST FIRST MIDDLE

Date of Birth: MM/DD/YYYY ______

Street Address: ______________________________

City: ______________ State: ______________ Zip Code: ______________

Home Telephone: ______________ Cell Phone: ______________

Do you have an email address you can share with us: ______________

We would like to stay in contact with you at all times. If you have a second residence, please provide us with that information

Street Address: ______________________________

City: ______________ State: ______________ Zip Code: ______________

Employer: ______________________________

Employer Address: ______________________________

City: ______________ State: ______________ Zip Code: ______________

Business Telephone: ______________

Marital status (please circle): Married Divorced Single Widow Living with Significant Other

In the event we are unable to contact you by the means you've provided above, we would like to have the ability to contact you through your spouse. Please provide the necessary information about your spouse below.

Spouse's Name: ______________________________
LAST FIRST MIDDLE

Spouse's Date of Birth MM/DD/YYYY ______

Spouse's Employer: ______________________________

Business Telephone: ______________

In case of an emergency, whom should we notify? Contact Name: ______________

Contact Information: ______________________________
HOME TELEPHONE CELLPHONE E-MAIL

Relationship: ______________

Signature: ______________________________ Date: MM/DD/YYYY ______

Prostate & Testicular History

Age of first intercourse experience: ______________________

Are you currently sexually active: ☐ YES ☐ NO

Have you had any sexually transmitted diseases (STDs): ☐ YES ☐ NO

Please list: ______________________

____

Have you had a sperm count: ☐ YES ☐ NO
What were the results of the sperm count: ______________________

Have you had the mumps: ☐ YES ☐ NO
When did you have the mumps: ______________________

Have you ever had testicular cancer: ☐ YES ☐ NO
What type of treatment did you receive: ______________________

Do you have prostate problems: ☐ YES ☐ NO

Do you have or have you had prostatitis: ☐ YES ☐ NO

Is your prostate enlarged: ☐ YES ☐ NO

Have you ever had prostate cancer: ☐ YES ☐ NO
What type of treatment did you receive: ______________________

Have you had blood in your urine: ☐ YES ☐ NO
If yes, when did this occur: ______________________
Please describe treatment used: ______________________

____

Do you have bladder or kidney issues: ☐ YES ☐ NO
If yes, please describe current treatment, if any: ______________________

____

Do you have erectile dysfunction: ☐ YES ☐ NO
If yes, please describe: ______________________

____

Are you suffering from the following (please check all that apply)

Fatigue:	☐ YES	☐ NO
Decrease of memory:	☐ YES	☐ NO
Decrease in energy level:	☐ YES	☐ NO
Decrease in sexual desire:	☐ YES	☐ NO

Are you suffering from the following (please check all that apply)

Anxiety:	☐ YES	☐ NO
Irritability:	☐ YES	☐ NO
Mood swings:	☐ YES	☐ NO
Migraines:	☐ YES	☐ NO
Memory loss:	☐ YES	☐ NO
Foggy thinking:	☐ YES	☐ NO
Muscle loss:	☐ YES	☐ NO
Poor response to exercise:	☐ YES	☐ NO
Poor recovery from exercise:	☐ YES	☐ NO

Please describe the way in which these issues have been dealt with:

____

____

____

____

Do you initiate intercourse:	☐ YES	☐ NO
Is intercourse satisfying:	☐ YES	☐ NO
Do you achieve orgasm:	☐ YES	☐ NO
Do you suffer from premature ejaculation:	☐ YES	☐ NO
How often do you have intercourse:	______________	
Is your sex drive similar as it was five years ago:	☐ YES	☐ NO

Please describe:

____

____

List any other sexual dysfunctions:

____

____

Have you experienced weight gain in the last 1-2 years: ☐ YES ☐ NO

If yes, please describe: ______________________________

____

____

Have you lost more than 10 pounds in less than a month: ☐ YES ☐ NO

If yes, why: ______________________________

Have you ever been tested for HIV/AIDS: ☐ YES ☐ NO

Are you HIV positive: ☐ YES ☐ NO

If yes, when did this occur: ______________________________

Please describe:

____

____

Have you fathered any children: ☐ YES ☐ NO

If yes, how many: ______________________________

Have you ever had your testosterone level taken in the past: ☐ YES ☐ NO

If yes, why: ______________________________

Please check the box that best describes your sexual orientation:

☐ Heterosexual ☐ Homosexual ☐ Bisexual

MEDICALHISTORY

Do you have **diabetes:** ☐ YES ☐ NO

Do you have or have you ever had **hypertension:** ☐ YES ☐ NO

Do you have **heart disease:** ☐ YES ☐ NO

Have you ever had a heart attack or stroke: ☐ YES ☐ NO

Have you ever had lung cancer: ☐ YES ☐ NO

If yes, please describe treatment used: ____________________

____

Have you ever had colon polyps: ☐ YES ☐ NO

If yes, please describe treatment used: ____________________

____

Have you ever had stomach/intestinal cancer: ☐ YES ☐ NO

If yes, what type: ____________________

Please describe treatment used: ____________________

Have you ever had leukemia or lymphoma: ☐ YES ☐ NO

If yes, what type: ____________________

Please describe treatment used: ____________________

____

Do you have a **heart murmur:** ☐ YES ☐ NO

Do you have or have you ever had **kidney disease:** ☐ YES ☐ NO

Have you ever been treated for a **psychiatric disorder:** ☐ YES ☐ NO

If yes, please name the disorder: ____________________

Have you ever had **rheumatic fever:** ☐ YES ☐ NO

Do you have **mitral valve prolapse:** ☐ YES ☐ NO

Have you ever had a **urinary tract infection:** ☐ YES ☐ NO

Have you ever had **hepatitis:** ☐ YES ☐ NO

If yes, please check which type:

☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ Other

Have you ever had **liver disease:** ☐ YES ☐ NO

Have you ever had **varicose veins:** ☐ YES ☐ NO

Have you ever had **phlebitis:** ☐ YES ☐ NO

Do you have any **thyroid problems:** ☐ YES ☐ NO

If yes, please check the problem:

☐ LowFunction ☐ Overactive ☐ Goiter ☐ Hashimoto

Have you ever had a **blood transfusion:** ☐ YES ☐ NO

Do you have a **lung disease:** ☐ YES ☐ NO

Do you have **asthma, emphysema** or **chronic bronchitis:** ☐ YES ☐ NO

Do you have **lupus, scleroderma, collagen disease:** ☐ YES ☐ NO

Do you have **arthritis:** ☐ YES ☐ NO

If yes, what type: ______________________________

Have you had any **major accidents:** ☐ YES ☐ NO

Do you have any **drug allergies:** ☐ YES ☐ NO

If yes, please list the drugs you are allergic to: ______________________________

____

Have you ever had any problems with your blood ☐ YES ☐ NO

If yes, please list the blood problems (such as anemia and excess blood cells: ______________________________

____

Have you ever had multiple myeloma: ☐ YES ☐ NO

Please describe treatment used: ______________________________

Please list all operations/hospitalizations (including year and reason):

____

____

____

____

Have you ever had any anesthesia complications: ☐ YES ☐ NO

If yes, please explain: ______________________________

____

Do you have an Internist or Family Physician: ☐ YES ☐ NO

Please list the name of the physician and a number where they may be reached:

Physician Name: ______________________________ Physician PhoneNumber: ______________________________

Are you currently taking any medications: ☐ YES ☐ NO

Please list the medications you are currently taking and the dosage amount:

____

____

Have you ever had your cholesterol checked: ☐ YES ☐ NO

If yes, what was the date it was last checked: ______________________

How was your cholesterol: ☐ Low ☐ Normal ☐ High

SOCIALHISTORY

Do you smoke cigarettes: ☐ YES ☐ NO

If yes, please to try list the number you smoke per day on average: ______________

Please list the number of years you have been smoking: ______________

Do you use recreational drugs: ☐ YES ☐ NO

Do you drink alcohol: ☐ YES ☐ NO

If yes, what type of alcohol do you drink: ______________________

How many drinks **per week**, on average, do you drink: ______________

Are you using any form of Testosterone or Hormone Therapy: ☐ YES ☐ NO

If yes, please check which type:

☐ Gel ☐ Cream ☐ Shots ☐ Pellets ☐ Other

Symptom Questionnaire

Patient Name: ______________________________ Today's Date: _

Date of Birth: _______________

Please rank each symptom's severity from zero (0) to five (5) (i.e., 0, 1, 2, 3, 4, 5)
0=you never experience the symptom
5=you experience the symptom severely and all the time

Dermatological

Dry Skin __/5
Course Skin __/5
Itchy Skin __/5
Dry, course hair __/5
Thinning/loss of hair __/5
Thinning eyebrows __/5
Brittle or ridges on nails __/5
Excess wax in ears __/5
Decreased sweat __/5
Paleness of skin or lips __/5
TOTAL __/50

Metabolism

Lethargy (low energy) __/5
Sensation of cold __/5
Heat intolerance (not hot flashes) __/5
Slow speech (non memory) __/5
Weight gain with little food intake __/5
Lack of appetite __/5
Lack of libido __/5
TOTAL __/30

Dryness (sicca)

Dry eyes __/5
Dry skin __/5
Dry mouth __/5
Dry nose __/5
Dry sinuses __/5
Dry vagina __/5
TOTAL __/30

Gastrointestinal

Constipation __/5
Diarrhea __/5
Irritable bowel syndrome __/5
GERD (reflux disease) __/5
TOTAL __/20

Reproductive

Delayed menstrual flow __/5
Excessive menstrual flow __/5
Painful menses __/5
Impotence (men only) __/5
TOTAL __/20

Mental/Emotional Well-being

Depression __/5
Irritability/mood swings __/5
Nervousness __/5
Anxiety __/5
Impaired memory __/5
Impaired focus __/5
TOTAL __/30

Cardiovascular/Respiratory

Chest pain __/5
Palpitations __/5
Atrial fibrillation __/5
Chronic cough of *unknown reason* __/5
Airflow obstruction (non smokers) __/5
Shortness of breath on physical exertion __/5
Shortness of breath in general __/5
TOTAL __/30

Swelling

Swollen ankles __/5
Swollen wrists __/5
Swollen eyelids __/5
Swollen, thick tongue __/5
Swollen face __/5
TOTAL __/25

Musculoskeletal

Muscle weakness __/5
Unexplained tingling or Numbness __/5
Body aches __/5

Muscle pain __/5
Joint pain __/5
Carpal tunnel syndrome __/5
Plantar fasciitis __/5
TOTAL __/35

Sleep

Difficulty getting to sleep __/5
Difficulty staying asleep __/5
Wake unrefreshed __/5
Sleep apnea __/5
Snoring __/5
TOTAL __/25

Past Medical Diagnosis of:

__Hypertension
__High cholesterol
__Infertility/Multiple miscarriage
__Anemia
__Hypothyroidism
__Thyroid Nodules
__Goiter
_ Hashimoto's thyroiditis
__Fibromyalgia
__Chronic Fatigue Syndrome
__Lupus
__Diabetes Type I
__Insulin resistance
_ Celiac's disease
__Multiple Sclerosis
__Rheumatoid arthritis
_ Srogren's disease
__Positive ANA
__Polycystic Ovarian Syndrome
__Live, work, or grow up near a nuclear power plant
__Currently taking Lithium or amiodarone (Cordarone)