COURI CENTER
for Gynecology and Integrative Women's Health

Male New Patient Information

Name: ____ Today's Date: __________________________

Date of Birth: ____

Street Address: ____

City: ____ State: ____________ Zip: _______________

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: _______________

Employer: ____

Employer Address: ____

City: ____ State: ____________ Zip: _______________

Business Telephone:_______________________________

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widow ☐ Significant Other

In the event we are unable to contact you by the means you have 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: ____

Spouse's Date of Birth: ____

Spouse's Employer: ____

Business Telephone: ____

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

Contact Home Telephone: ____________________________ Contact Cell Phone: ____________________________

Relationship: ____

Signature: ____ Date: ____________________

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Male New Patient Information

What is the reason for your visit today? Please describe the symptoms & be specific:

____

____

____

____

____

How did you hear about us?

____

____

____

Male New Patient Information

Page 3 - Prostate & Testicular Health

Are you currently sexually active? ◯ Yes ◯ No

Have you had any sexually transmitted diseases (STDs): ◯ Yes ◯ No

Please list: ____

____

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 (I.e. removal, chemo/radiation):

____

Have you ever had an injury to your testicles? ◯ Yes ◯ No

Have you ever had an infection involving your testicles? ◯ Yes ◯ No

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 ever 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: ____

Male New Patient Information

Do you have **diabetes**? ◯ Yes ◯ No

Do you have or have you ever had **hypertension**? ◯ Yes ◯ No

Do you have **heart disease**? ◯ Yes ◯ No

Do you have **any issues with your cholesterol**? ◯ Yes ◯ No

If yes, please describe: ____

Have you ever had a **heart attack**? ◯ Yes ◯ No

Have you ever had a **stroke**? ◯ Yes ◯ No

Do you have a **heart murmur**? ◯ Yes ◯ No

Have you had **blood clots in your legs or lungs**? ◯ 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 **hepatitis**? ◯ Yes ◯ No

If yes, please check which type: ☑ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ Other

Have you ever had a **liver disease**? ◯ Yes ◯ No

Do you have any **thyroid problems**? ◯ Yes ◯ No

Have you ever been diagnosed with **pituitary gland disease**? ◯ Yes ◯ No

Do you have a history of **lung disease**? ◯ Yes ◯ No

Have you ever been diagnosed with **Obstructive Sleep Apnea (OSA)?** ◯ Yes ◯ No

Have you ever been diagnosed with **cancer** of any kind? ◯ Yes ◯ No

If yes, are you currently undergoing any treatment? ◯ Yes ◯ No

If yes, please describe type and current treatment, if any: ____

Do you have **arthritis**? ◯ Yes ◯ No

If yes, what type? ____

Do you have a history of any **congenital diseases** including, but not limited to Klinefelter or Syndrome or Noonan Syndrome? ◯ Yes ◯ No

If yes, how is it treated? ____

Do you have a history of **autoimmune disorders**? ◯ Yes ◯ No

Do you have a history of **any blood disorders?** ◯ Yes ◯ No

Are you currently or have you ever been **anemic**? ◯ Yes ◯ No

Have you ever had a **blood transfusion**? ◯ Yes ◯ No

Personal History

Do you have any drug **allergies**? ◯ Yes ◯ No

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

____

Please list any other **health issues or medical diagnoses** that you have that were not mentioned above:

____

____

Please list any **medications** you are currently taking (the name as well as the dose):

____

____

Please list all **major surgeries** (including year and reason): ____

____

Please list any other **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 Phone Number: ______________________

____

Family History

Do you have a family history of:

☐ Breast cancer ☐ Colon cancer ☐ Ovarian cancer ☐ Osteoporosis ☐ Diabetes ☐ Hypertension

☐ Heart Disease ☐ Kidney Disease ☐ Pancreatic cancer

If yes, who in your family history: ______________________________________

Social History

Do you smoke cigarettes? ○ Yes ○ No

If yes, please list the number of cigarettes 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