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: ______________________________

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

Emergency Contact: ______________________ Contacts Phone #: ______________________

Employer: ____

Employer Address: ____

City: ______________________________ State: __________ Zip: __________

Business Telephone: ______________________

1. Primary Insurance Information: ____

Address: ______________________ City: ____________ State: __________ Zip: __________

Phone:(____) ______________________ EXT: ________

Policy #, Medicare #: ______________________ Group/Certificate #______________________

Insured Date of Birth: ________/________/________

Insured Name (if different): ______________________________

2. Secondary Insurance Information: ____

Address: ______________________ City: ____________ State: __________ Zip: __________

Phone: (____) ______________________ EXT: ________

Policy #, Medicare #: ______________________ Group/Certificate #______________________

Insured Date of Birth: ________/________/________

Insured Name (if different): ______________________________

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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

Page 4 - Medical History

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　Pancreatic cancer　Osteoporosis

Hypertension　Heart Disease　Kidney Disease　Diabetes

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