COURI CENTER
for Gynecology and Integrative Women's Health

Male New Patient Information

Today's Date: ______________________

Name: ____ **Date of Birth:** ____________________________

Address: ____ **Home Phone:** ____________________________

City: ________________ **State:** ___________ **Zip:** _____________ **Cell Phone:** ______________________________

Employer: ____ **Work Phone:** _____________________________

Email: ____

Preferred Pharmacy: _________________________________ **Pharmacy Address:** ____________________________

Primary Care Provider: _______________________________ **Urologist:** _____________________________________

Marital Status (please check): Married Divorced Single Widow Significant Other

Emergency Contact: ___________________________________ **Contact Phone #:** _________________________

Relationship to Patient: _______________________________

Primary Insurance Information: ____

Address: ____________________________ City: _________________ State: ____________ Zip: _____________________

Phone: _____________________________ Ext: __________________

Policy #, Medicare #: ____ Group/Certificate #: _________________________

Insured Name (if different than patient): ________________________ Insured Date of Birth: _______________________

Secondary Insurance Information: ____

Address: ____________________________ City: _________________ State: ____________ Zip: _____________________

Phone: _____________________________ Ext: __________________

Policy #, Medicare #: ____ Group/Certificate #: _________________________

Insured Name (if different than patient): ________________________ Insured Date of Birth: _______________________

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

____

____

How did you hear about us?

____

____

CURRENT MEDICATIONS

Complete below **OR** attach a current medication list

Please list ALL your current PRESCRIPTION and NON-PRESCRIPTION medications, including supplements and vitamins.		
Medication Name	**Strength (i.e. mg, mcg, IU)**	**How Taken (i.e. 2 tablets twice daily)**

MEDICAL ALLERGIES

Allergy	**Reaction**

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Page 3 - Prostate & Testicular Health

Are you currently **sexually active**? ☐ Yes ☐ No

If yes, are you **trying for a pregnancy**? ☐ Yes ☐ No

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

If yes, please list: ____

Have you had the **mumps**? ☐ Yes ☐ No If yes, when? __________

Have you ever had **testicular cancer**? ☐ Yes ☐ No If yes, when? __________

Have you ever had **prostate cancer**? ☐ Yes ☐ No If yes, when? __________

If yes, what type of treatment did you receive: ____

Do you have **erectile dysfunction**? ☐ Yes ☐ No

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

What type of treatment did you receive: ____

Have you had **blood in your urine**: ☐ Yes ☐ No If yes, when? __________

If yes, please describe treatment used: ____

Do you have **bladder or kidney issues**: ☐ Yes ☐ No

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

Have you ever had your testosterone level taken in the past? ☐ Yes ☐ No

If yes, when? ____________________________ If yes, where? ________________________________

Are you currently using any form of Testosterone or Hormone Therapy? ☐ Yes ☐ No

If yes, please check which type: ☐ Gel ☐ Cream ☐ Shots ☐ Pellets ☐ Other

Male New Patient Information

Page 4 - Medical History

Have you ever had a **stroke (CVA or TIA)**? □ Yes □ No

Have you ever had a **blood clot in your legs or lungs**? □ Yes □ No

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

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

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

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

Do you have **high cholesterol**? □ Yes □ No

Do you have **diabetes**? □ Yes □ No

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

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

Have you ever had **liver disease**? □ Yes □ No

Have you ever had **hepatitis**? □ Yes □ No If yes, which type: □ A □ B □ C □ Other

Do you have or have you ever had **kidney disease**? □ Yes □ No

Do you have any history of **congenital diseases** including, but not limited to, Klinefelter Syndrome or Noonan Syndrome? □ 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, please describe type and current treatment, if any: ____

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

____

____

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Page 5 – Surgical, Social, and Family History

Surgical History

Please list any major surgeries or hospitalizations (including year and reason)

Surgery/Hospitalization	Year	Reason

Social History

Do you smoke cigarettes or vape? ☐ Yes ☐ No

If yes, how much? ___________________________ 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? ___________________

Do you exercise regularly? Yes No If yes, how often do you exercise? __________________

What is your occupation? ___________________________

Family History

Please check the appropriate box and specify which family member

☐ Prostate Cancer ____________ ☐ Breast Cancer ________________ ☐ Other: ___________________________

☐ Pancreatic Cancer ___________ ☐ Diabetes ____________________ ___________________________________

☐ Colon Cancer _______________ ☐ Heart Disease ________________ ___________________________________

☐ Ovarian Cancer ______________ ☐ High Blood Pressure ___________ ___________________________________

Male Hormone Evaluation Intake Sheet

Today's Date: ______________________________

Name: ____ **Date of Birth**: ______________________________

Date of last prostate exam: _____________________________ **Where?** ____________________________________

Symptoms	Yes	No		Yes	No
Erectile Dysfunction			Trouble sleeping/insomnia		
Decreased libido (sex drive)			Decreased self confidence		
Brain fog/Decreased mental clarity			Low motivation		
Loss of memory/trouble concentrating			Weight gain/increased body fat		
Fatigue/Decreased energy			Bone loss/decreased bone density		
Depression			Decreased muscle mass/strength		
Anxiety			Harder to build/maintain muscle		
Irritability			Decreased exercise tolerance/longer recovery time		

Are you currently on any testosterone replacement therapy (HRT) at this time? Yes No

If yes, name of HRT? ____

Have you been on any testosterone replacement in the past? Yes No

If yes, name of HRT? ____

Have you had a prostatectomy? Yes No

If yes, when and for what reason? ____

Do you have any history of cancer of any kind? Yes No

Do you have any history of blood clots in your legs (DVT) or lungs (pulmonary embolism)? Yes No

Do you have any medical problems that require you to see your doctor regularly? Yes No

If yes, please list: ____

Have you been hospitalized for any reason in the last year? Yes No

If yes, for what reason? ____

Do you have any history of joint replacement? Yes No

If yes, which joints? ____

Do you have a family history of prostate cancer? Yes No

If yes, whom and at what age? ____