SENARA MEN'S HEALTH CENTER: NEW PATIENT HISTORY

GENERAL INFORMATION

Today's Date _____ How Did You Hear About Us? _____

First Name _____ Last Name _____

Date Of Birth _____ Age _____ Gender: □ M □ F

Address _____

City _____ State _____ Zipcode _____

Phone (Home) _____ (Cell) _____ (Work) _____

E-Mail _____

Occupation _____ Marital Status □ M □ S □ D □ W □ Other

Emergency Contact Name _____ Relationship _____

Emergency Contact Phone _____

TREATMENT GOALS

What areas of improvement are you interested in?

□ Erectile Dysfunction □ Low Libido □ Penile Sensitivity □ Hair loss □ Other_____

When did the problem begin? _____ Severity of the problem? □ Mild □ Moderate □ Severe

What medications or supplements are you taking for this condition?

_____

Did the medication/supplements work? □ Yes □ No

Please describe the progression of the problem, including prior treatments and approaches to addressing it.

REPRODUCTIVE HEALTH

Do you have any of the following health conditions? *Check all applicable.*

□ Testicular Mass □ Testicular Pain □ Prostate Enlargment □ Prostate Infection

□ Change in Libido □ Impotence □ Vasectomy □ Premature Ejaculation

□ Difficulty obtaining an erection □ Difficulty maintaining an erection

□ Loss of Control of Urine □ Urinary urgency/hesitancy/change in stream

□ Urination at Night # of time per night ___ □ STDs (list) _____

MEDICAL HISTORY

Illnesses/Conditions: ***Check appropriate Box: YES****-a condition you currently have,* ***PAST****-a condition you've had in the past*

Gastrointestinal	
Irritable Bowel Syndrome	□ Yes □ Past
GERD (reflux)	□ Yes □ Past
Crohn's Disease/Ulcerative Colitis	□ Yes □ Past
Peptic Ulcer Disease	□ Yes □ Past
Celiac Disease	□ Yes □ Past
Gallstones	□ Yes □ Past
Other:	□ Yes □ Past
Respiratory	
Bronchitis	□ Yes □ Past
Asthma	□ Yes □ Past
Emphysema	□ Yes □ Past
Pneumonia	□ Yes □ Past
Sinusitis	□ Yes □ Past
Sleep Apnea	□ Yes □ Past
Other:	□ Yes □ Past
Urinary/Genital	
Kidney Stones	□ Yes □ Past
Gout	□ Yes □ Past
Interstitial Cystitis	□ Yes □ Past
Frequent Yeast Infections	□ Yes □ Past
Frequent Urinary Tract Infections	□ Yes □ Past
Sexual Dysfunction	□ Yes □ Past
Sexually Transmitted Diseases	□ Yes □ Past
Other:	□ Yes □ Past
Endocrine/Metabolic	
Diabetes	□ Yes □ Past
Hypothyroidism (low thyroid)	□ Yes □ Past
Hyperthyroidism (overactive thyroid)	□ Yes □ Past
Infertility	□ Yes □ Past
Metabolic Syndrome/Insulin Resistance	□ Yes □ Past
Eating Disorder	□ Yes □ Past
Hypoglycemia	□ Yes □ Past
Other:	□ Yes □ Past
Inflammatory/Immune	
Rheumatoid Arthritis	□ Yes □ Past
Chronic Fatigue Syndrome	□ Yes □ Past
Food Allergies	□ Yes □ Past
Environmental Allergies	□ Yes □ Past
Multiple Chemical Sensitivities	□ Yes □ Past
Autoimmune Disease	□ Yes □ Past
Immune Deficiency	□ Yes □ Past
Mononucleosis	□ Yes □ Past
Hepatitis	□ Yes □ Past
Other:	□ Yes □ Past

Musculoskeletal	
Fibromyalgia	□ Yes □ Past
Osteoarthritis	□ Yes □ Past
Chronic Pain	□ Yes □ Past
Other:	□ Yes □ Past
Skin	
Eczema	□ Yes □ Past
Psoriasis	□ Yes □ Past
Acne	□ Yes □ Past
Skin Cancer	□ Yes □ Past
Other:	□ Yes □ Past
Cardiovascular	
Angina	□ Yes □ Past
Heart Attack	□ Yes □ Past
Heart Failure	□ Yes □ Past
Hypertension (high blood pressure)	□ Yes □ Past
Stroke	□ Yes □ Past
High Blood Fats (cholesterol, triglycerides)	□ Yes □ Past
Rheumatic Fever	□ Yes □ Past
Arrythmia (irregular heart rate)	□ Yes □ Past
Murmur	□ Yes □ Past
Mitral Valve Prolapse	□ Yes □ Past
Other:	□ Yes □ Past
Neurologic/Emotional	
Epilepsy/Seizures	□ Yes □ Past
ADD/ADHD	□ Yes □ Past
Headaches	□ Yes □ Past
Migraines	□ Yes □ Past
Depression	□ Yes □ Past
Anxiety	□ Yes □ Past
Autism	□ Yes □ Past
Multiple Sclerosis	□ Yes □ Past
Parkinson's Disease	□ Yes □ Past
Dementia	□ Yes □ Past
Cancer	
Lung	□ Yes □ Past
Breast	□ Yes □ Past
Colon	□ Yes □ Past
Ovarian	□ Yes □ Past
Prostate	□ Yes □ Past
Skin	□ Yes □ Past
Other:	□ Yes □ Past

CURRENT HEALTH AND WELLNESS CARE PROFESSIONALS

Are you currently seeing a physician for any reason. If yes, explain reason: □ Yes □ No

_____

When, where and from whom did you last receive medical or health care?

_____

MEDICATIONS AND SUPPLEMENTS

Please list all current prescription medications, over the counter drugs, supplements, and vitamins you take regularly. Please include any you have taken in the past 3 months.

Medication/OTC/Supplement	Dosage	Frequency	Last Taken

SURGERIES AND HOSPITALIZATIONS

Please list all surgeries, hospitalizations, or other medical procedures you have had.

Reason/diagnosis	Year	Physician	Hospital

ALLERGIES/SENSITIVITIES

Please indicate if you have any allergies or sensitivities. These can include medications, foods, environmental, animals, chemicals, pollutants, or other substances to which you adversely react.

_____

_____

LIFESTYLE & GENERAL HEALTH

How many hours of sleep do you get each night on average? □ Less than 4 □ 4-6 □ 7-8 □ More than 8

Do you have problems with: □ Falling asleep? □ Staying asleep? □ Snoring? □ Insomnia?

Do you feel rested upon awakening? □ Yes □ No

Do you use sleeping aids? □ Yes □ No Explain: _____

Do you exercise? □ Yes □ No If NO, please explain: _____

If YES, how often? □ 1x/wk or less □ 2-3x/wk □ 3-5x/wk □ 5-7x/wk

Are there any problems that limit exercise? □ Yes □ No

If yes, explain: _____

Do you currently smoke or chew tobacco? □ Yes □ No

If yes, how much/often? _____ How many years?_____

What type? □ Cigarettes □ Smokeless □ Pipe □ Cigar □ E-Cig □ Other _____

Have you attempted to quit? □ Yes □ No What methods have you tried? _____

Did you smoke/chew previously? □ Yes □ No If yes, packs per day: _____ Number of years _____

Do you have regular second hand smoke exposure? □ Yes □ No

How many alcoholic beverages do you drink in a week? □ 1-3 □ 4-6 □ 7-10 □ >10 □ None

Type(s): □ Beer □ Wine □ Spirits □ Mixed Drinks □ Other

Have you ever or are you currently using any recreational drugs? □ Yes □ No

If yes, how much/often? _____ How many years? _____

Type(s): _____

How long has it been since you last used any drugs?_____

Have you ever been addicted to any prescription drugs? If yes, please explain below. □ Yes □ No

_____

Do you feel you have an excessive amount of stress in your life? □ Yes □ No

How much stress do each of the following cause on a daily basis? (Rate on scale of 1-10, 10 highest)

Work ___ Family ___ Social ___ Finances ___ Health ___ Other ____

Do you use relaxation techniques? □ Yes □ No If yes, how often? _____

Have you ever been abused, a victim of crime, or experienced a significant trauma? □ Yes □ No

Do you have regular exposure to any of the following: (check all that apply)

□ Mold	□ Water leaks	□ Renovations	□ Old paint
□ Paints	□ Damp environments	□ Carpets or rugs	□ Herbicides
□ Pesticides	□ Regular contact with smokers	□ Cleaning chemicals	□ Airplane travel
□ Stagnant or stuffy air	□ Electromagnetic Radiation	□ Harsh chemicals (solvents, glues, acids, etc)	
□ Heavy metals (lead, mercury, etc)		□ Other: _____	

Is there history of a significant exposure to any harmful chemicals? □ Yes □ No

If yes: Chemical name, length of exposure, date: _____

ACKNOWLEDGEMENTS AND CONSENT

To set clear expectations, improve communications, and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initial

____ I instruct the health care practitioner to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the health care offered in this practice is based on the best available evidence.

____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Print Name: _____ Date: _____

Signature: _____