Chapel Hill Hormone Therapy

Male New Patient Form

Name:_____Date of birth:_____Age: _____

Primary care provider:_____Specialists:_____

What is your native language? □ English □ Spanish Other _____

What is your race? □ American Indian/Alaska Native □ Asian □ Black or African American
□ Native Hawaiian/Other Pacific Islander □ White □ Multiracial □ Prefer not to answer

What is your ethnicity? □ Hispanic □ Not Hispanic □ Prefer not to answer

Preferred pharmacy: name_____ location _____

Sexual history:

Are you sexually active? □ Yes □ No

If sexually active, are you active with: □1 partner □ multiple partners □ men □ women □ men and women

History of sexually transmitted infections? ☐ Yes ☐ No

Medications

List all current **medications** (dose and frequency):

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

List all current **supplements:**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Are you allergic to any medications? □ Yes □ No

Please specify any allergies: _____

_____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Do you have any of the following symptoms at this time? Please check all that apply.

General
□ Excessive sweating
□ Unusual fatigue
□ Decline in general well-being

Gastrointestinal
□ Abdominal pain
□ Constipation
□ Diarrhea
□ Heartburn
□ Nausea and vomiting

Breast
□ Breast pain
□ Breast lumps
□ Nipple discharge

Metabolic/endocrine
□ Cold intolerance
□ Heat intolerance
□ Excessive thirst

Eye/ear/nose/throat
□ Hearing loss
□ Sinus pressure

Genitourinary
□ Blood in urine
□ Urinary incontinence

Dermatologic
□ Rash
□ Changes in moles

Musculoskeletal
□ Joint pain
□ Joint swelling

Respiratory
□ Cough
□ Shortness of breath
□ Wheezing

Reproductive
□ Low libido
□ Erectile dysfunction
□ Infertility

Neurological
□ Headaches
□ Seizures
□ Memory loss

Hematologic
□ Easy bleeding
□ Easy bruising
□ Enlarged lymph nodes

Cardiovascular
□ Chest pain
□ Heart palpitations
□ Swelling of legs

Mental health
□ Anxiety
□ Depression
□ Insomnia
□ Suicidal thoughts

Immunologic
□ Environmental allergies
□ Food allergies

Social history
Do you currently use tobacco products? □ Yes □ No
Have you **ever** used tobacco products? □ Yes □ No
If yes, specify type of tobacco: _____ Number of years of use_____ Age when quit _____
Do you drink alcohol? □ Yes □ No
Type of alcohol: □ beer □ wine □ liquor
Number of drinks per week:_____
Do you use recreational drugs? □ Yes □ No If yes, please list type(s): _____

Marital status: ☐ Single ☐ Married ☐ Domestic partner ☐ Separated ☐ Divorced ☐ Widowed

Who do you live with?_____
Do you exercise? What type and how often?_____
Nutrition: Briefly describe your diet_____ ☐ Vegetarian ☐ Vegan

Occupation:_____ Place of employment: _____

Circle all conditions that apply to you:

Allergies
Anemia
Anxiety
Asthma
Arthritis
Cancer
- Testicular
- Prostate
- Other cancer _____

Depression
Diabetes
DVT
Elevated PSA
Enlarged prostate
Heart disease
High blood pressure
High cholesterol
Kidney stones
Fibromyalgia
Migraine headaches
Osteoporosis
Reflux
Thyroid disease
Chronic liver disease
Trouble passing urine or taking Flomax, Avodart

☐ Other illnesses _____

List any hospitalization or surgeries: ☐ None _____

Prostate

Last prostate exam _____

Last PSA test _____

Screening tests:

Bone density:_____ Results: ☐ Normal ☐ Osteopenia ☐ Osteoporosis

Colonoscopy:_____ Results: ☐ Normal ☐ Abnormal _____

Family history:

	High Blood Pressure	Diabetes	High Cholesterol	Heart Disease	Stroke	Breast Cancer	Prostate Cancer	Colon Cancer	Osteoporosis	Mental Illness	Substance Abuse	Dementia	Thyroid disease
Father													
Mother													
Daughter													
Son													
Brother													
Sister													
Mat Grandfather													
Mat Grandmother													
Pat Grandfather													
Pat Grandmother													
Mat Aunt													
Mat Uncle													
Pat Aunt													
Pat Uncle													