PATIENT PROFILE DEMOGRAPHICS

(fill out prior to going to appointments so provider can get best information possible)

Name: _____ Date: _____

Address: _____ City: _____

State: _____ Zip code: _____ Phone: _____

Age: _____ DOB: _____ Driver's Lic #: _____

Email address: _____

MEDICAL QUESTIONNAIRE PORTION

(please circle either yes or no if you have a personal history of)

Diabetes	YES	NO	HIV / AIDS	YES	NO
High blood pressure	YES	NO	Epilepsy / Seizures	YES	NO
Heart attack	YES	NO	Depression	YES	NO
Heart disease	YES	NO	Kidney disease	YES	NO
Coronary artery disease	YES	NO	Liver disease	YES	NO
Blocked artery	YES	NO	Multiple sclerosis	YES	NO
Stroke or TIA (mini stroke)	YES	NO	Bowel problems	YES	NO
High cholesterol/triglycerides	YES	NO	Hepatitis	YES	NO
Prostate disease (BPH)	YES	NO	Blood transfusion	YES	NO
Prostate cancer	YES	NO	Parkinson's disease	YES	NO
Peyronie's disease (curved/bent penis)	YES	NO	Bleeding disorder	YES	NO
History of sexually transmitted disease	YES	NO	Tuberculosis	YES	NO

Other:_____

Current Medications: (pills, injections, vitamins, supplements, OTC, others) _____

_____

Allergies: reaction to any medication or substance in the past: Yes / No _____

Surgeries: _____Prostate _____Scrotum/testes _____Vasectomy _____Hernia _____Other_____

Prior Urological Issues: _____ Penis _____ Testicles _____ Prostate _____ Bladder _____ Kidneys _____ Urine

Past Injuries: _____ Penis /Scrotum _____ Pelvis _____ Back/Spine _____ Head/Neck _____ Other _____

Substance use: Alcohol Yes / No - How much? / How often? _____

Smoking Yes / No - How much? / How often? _____

Marijuana / Cocaine / Meth? Yes / No - Last use? _____

Social History: _____Single _____Married _____Divorced _____Separated _____Widowed

Physical Activity level: _____Inactive _____Light activity _____Moderate activity _____Heavy activity