DR MERCEDES @ WESTCHASE

MALE PATIENT INFORMATION

NAME: _____ TODAY'S DATE: _____

DATE OF BIRTH: _____ MARITAL STATUS: _____

SEXUAL HISTORY

1. AGE OF FIRST SEXUAL CONTACT: _____
2. ARE YOU SEXUALLY ACTIVE? _____
3. DO YOU HAVE A HISTORY OF SEXUALLY TRANSMITTED DISEASES? PLEASE LIST BELOW

   _____

4. HAVE YOU HAD A SPERM COUNT? _____
5. HAVE YOU HAD THE MUMPS? _____
6. HAVE YOU HAD TESTICULAR CANCER? _____
7. DO YOU HAVE PROSTATE PROBLEMS? _____
8. HAVE YOU HAD BLOOD IN THE URNE? _____
9. HAVE YOU HAD ANY BLADDER OR KIDNEY PROBLEMS? _____
10. DO YOU HAVE ERCTILE DYSFUNCTION? _____
11. DO YOU HAVE
    FATIGUE ___ DECREASE OF MEMORY ___ DECREASE OF ENERGY LEVEL ___
    DECREASE OF SEXUAL DRIVE ___
12. DO YOU SUFFER FROM

    ANXIETY ___ IRRITABILITY ___ MOOD SWINGS ___ MIGRAINES ___

13. HOW HAVE YOU DEALT WITH THESE SYMPTOMS? _____

    _____

14. DO YOU INITIATE INTERCOURSE? _____
15. IS INTERCOURSE SATISFYING? _____
16. DO YOU ACHIEVE ORGASM? _____
17. DO YOU SUFFER FROM PREMATURE EJACULATION? _____
18. HOW OFTEN DO YOU HAVE INTERCOURSE? _____
19. IS YOUR SEX DRIVE THE SAME AS IT WAS FIVE YEARS AGO? _____
20. LIST ANY OTHER SEXUAL DYSFUNCTIONS: _____
21. HAVE YOU EXPERIENCED WEIGHT GAIN IN THE LAST ONE-TWO YEARS? _____
22. HAVE YOU LOST GREATER THAN 10 POUDS IN LESS THAN A MONTH? _____
23. ARE YOU HIV POSITIVE? _____
24. HAVE YOU EVER BEEN TESTED FOR AIDS? _____
25. HAVE YOU FATHERED ANY CHILDREN? IF YES HOW MANY_____

26. HAVE YOU HAD YOUR TESTOSTERONE LEVEL TAKEN? _____
27. LIST CURRENT MEDICATION; _____

    _____

28. SEXUAL ORIENTATION?

    HETEROSEXUAL___ HOMOSEXUAL ___ BISEXUAL ___

PAST MEDICAL HISTORY

1. DO YOU HAVE DIABETES? _____
2. DO YOU HAVE/HAD HYPERTENSION? _____
3. DO YOU HAVE HEART DISEASE? _____
4. DO YOU HAVE A HEART MURMUR? _____
5. DO YOU HAVE/HAD KIDNEY DISEASE? _____
6. HAVE YOU EVER BEEN TREATED FOR PHYCHIATRIC PROBLEMS? _____
7. HAVE YOU EVER HAD RHEUMATIC FEVER? _____
8. DO YOU HAVE MITRAL VALVE PROLAPSE? _____
9. HAVE YOU EVER HAD A URINARY TRACT INFETION? _____
10. HAVE YOU EVER HAD HEPATITI/LIVER DISEASE? _____
11. HAVE YOU EVER HAD VARICOSITIES/PHLEBITIS? _____
12. DO YOU HAVE ANY THYROID PROBLEMS? _____
13. HAVE YOU HAD ANY MAJOR ACCIDENTS? _____
14. HAVE YOU EVER HAD ANY BLOOD TRANSFUSIONS? _____
15. DO YOU HAVE ASTHMA/LUNG DISEASE? _____
16. DO YOU HAVE LUPUS? _____
17. DO YOU HAVE ARTHRITIS? _____
18. DO YOU HAVE DRUG ALLERGIES? _____
19. PLEASE LIST ANY SURGERIES: _____
20. PLEASE LIST ANY OPERATIONS OR HOSPITALIXATIONS: _____
21. HAVE YOU HAD ANY ANETHESIA COMPLICATIONS? _____
22. HAVE YOU EVER BEEN ANEMIC? _____

SOCIAL HISTORY

1. DO YOU SMOKE CIGARETTES? ___ IF YES NUMBER PER DAY AND YEARS _____
2. DO YOU USE STREET DRUGS? ____ IF YES WHAT _____
3. DO YOU DRINK ALCOHOL? ____ IF YES HOW MANY PER DAY _____