Dr Mercedes @ Westchase

Male Patient Information

Name: _____ Today's Date: _____
LAST MIDDLE FIRST

Date of Birth: _____ Social Security #: _____

Street address: _____

City: _____ State: _____ Zip: _____

Phone numbers: Home _____ Cell_____

Do you have an email address you can share with us?_____

We would like to stay in contact with you at all times. Please provide us with a summer residence location if you have one: _____

Patient employed by: _____

Business address: _____

Business phone: _____

Marital status: (please circle) Married Divorced Single Widow Living with Sig. Other

Spouse's Name: _____
FIRST LAST

Spouse's date of birth: _____ Social Security #: _____

Spouse employed by: _____ Business phone:_____

In case of emergency, whom should we notify? _____

Phone number(s): _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. In order to control the cost of billing, we request that our charges for office visits be paid at the conclusion of each visit. If this account is assigned to an attorney for collections and/or suit, the prevailing party shall be entitled to reasonable attorney fees and costs of collection. I authorize the release of information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance and any other insurance to:_____. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature: _____ Date: _____

SEXUAL HISTORY

1. Age of first sexual contact: _____
2. Are you sexually active? ❑ YES ❑ NO
3. Do you have a history of Sexually Transmitted Diseases? ❑ YES ❑ NO
   If yes, please list: _____
4. Have you had a sperm count? ❑ YES ❑ NO
   Results: _____
5. Have you had the Mumps? ❑ YES ❑ NO
   Date: _____
6. Have you had Testicular Cancer? ❑ YES ❑ NO
   Date: _____
7. Do you have Prostate Problems? ❑ YES ❑ NO
   If yes, please describe: _____
8. Have you had blood in your urine? ❑ YES ❑ NO
   If yes, when & treatment: _____
9. Have you had any bladder or kidney problems? ❑ YES ❑ NO
   If yes, when & treatment: _____
10. Do you have erectile dysfunction? ❑ YES ❑ NO
    If yes, please describe: _____
11. Do you have:
    - Fatique? ❑ YES ❑ NO
    - Decrease of memory? ❑ YES ❑ NO
    - Decrease of energy level? ❑ YES ❑ NO
    - Decrease of sexual drive? ❑ YES ❑ NO
12. Do you suffer from:
    - Anxiety? ❑ YES ❑ NO
    - Irritability? ❑ YES ❑ NO
    - Mood swings? ❑ YES ❑ NO
    - Migraines? ❑ YES ❑ NO
13. How have you dealt with these symptoms?

_____

_____

_____

_____

14. Do you initiate intercouse? ❑ YES ❑ NO
15. Is intercourse satisfying? ❑ YES ❑ NO
16. Do you achieve orgasm? ❑ YES ❑ NO
17. Do you suffer from premature ejaculation? ❑ YES ❑ NO
18. How often do you have intercourse?

_____

19. Is your sex drive the same as it was five years ago? ❑ YES ❑ NO
    Describe: _____

20. List any other sexual dysfunctions:

_____

_____

_____

21. Have you experienced weight gain in the last one-two years? ❑ YES ❑ NO
    If yes, please describe: _____
22. Have you lost greater than 10 pounds in less than a month? ❑ YES ❑ NO
    If yes, why? _____
23. Are you HIV positive? ❑ YES ❑ NO
    If yes, when? Describe: _____

_____

24. Have you ever been tested for AIDS? ❑ YES ❑ NO
    Results? _____
25. Have you fathered any children? ❑ YES ❑ NO
    If yes, how many? _____
26. Have you had your Testosterone level taken? ❑ YES ❑ NO
27. List current medications:

_____

_____

_____

28. Sexual Orientation?
    ❑ Heterosexual ❑ Homosexual ❑ Bisexual

PAST MEDICAL HISTORY

1. Do you have diabetes? ❑ YES ❑ NO
2. Do you have/had hypertension? ❑ YES ❑ NO
3. Do you have heart disease? ❑ YES ❑ NO
4. Do you have a heart murmur? ❑ YES ❑ NO
5. Do you have/had kidney disease? ❑ YES ❑ NO
6. Have you ever been treated for psychiatric problems? ❑ YES ❑ NO
7. Have you ever had rheumatic fever? ❑ YES ❑ NO
8. Do you have mitral valve prolapse? ❑ YES ❑ NO
9. Have you ever had a urinary tract infection? ❑ YES ❑ NO
10. Have you ever had hepatitis/liver disease? ❑ YES ❑ NO
11. Have you ever had varicosities/phlebitis? ❑ YES ❑ NO
12. Do you have any thyroid problems? ❑ YES ❑ NO
13. Have you had any major accidents? ❑ YES ❑ NO
14. Have you ever had any blood transfusions? ❑ YES ❑ NO
15. Do you have asthma/lung disease? ❑ YES ❑ NO
16. Do you have lupus? ❑ YES ❑ NO
17. Do you have arthritis? ❑ YES ❑ NO

18. Do you have any Drug Allergies? ❑ YES ❑ NO
If yes, please list:_____
19. Please list any surgeries: _____

_____

_____

_____

_____

20. Please list any other operations/hospitalizations (include year & reason):

_____

_____

_____

_____

21. Have you had any anesthesia complications: ❑ YES ❑ NO
If yes, please list:_____
22. Have you ever been anemic? ❑ YES ❑ NO
23. Do you have an Internist or Family Doctor? ❑ YES ❑ NO
Please list name, phone number:

_____

_____

_____

24. Have you had your cholesterol checked? ❑ YES ❑ NO
If yes, date last checked? _____
Was it normal? ❑ YES ❑ NO

SOCIAL HISTORY

1. Do you smoke cigarettes? ❑ YES ❑ NO
If yes, number per day? _____ Number of years? _____
2. Do you use street drugs? ❑ YES ❑ NO
3. Do you drink alcohol? ❑ YES ❑ NO
If yes, how much per day? _____