OBGYN
Specialists of Columbus

Return by email to admin@obgynsoc.com or by fax to (706) 324-0473

1604 12th Street Columbus GA 31906 706-324-0471

Name:_____ Date of birth: _____

# MALE PATIENT QUESTIONNAIRE & HISTORY

Name:_____ Date:_____

Date of birth:_____ Age:_____ Weight:_____ Occupation:_____

Home address: _____

City:_____ State:_____ Zip: _____

Home phone:_____ Cell phone:_____ Work: _____

Preferred contact number: _____

May we send messages via text regarding appts to your cell? ☐ Yes ☐ No

Email address:_____ May we contact you via email? ☐ Yes ☐ No

In case of emergency contact:_____ Relationship: _____

Home phone:_____ Cell phone:_____ Work:_____

Primary care physician's name:_____ Phone: _____

Address: _____
Address / City / State / Zip

Marital status (check one): ☐ Married ☐ Divorced ☐ Widow ☐ Living with partner ☐ Single

In the event we cannot contact you by the means you have provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Name:_____ Relationship: _____

Home phone:_____ Cell phone:_____ Work: _____

**Social:**

| | | | |
|---|---|---|---|
| ☐ I am sexually active. | OR | ☐ I want to be sexually active. | ☐ I do not want to be sexually active. |
| ☐ I have completed my family. | OR | ☐ I have NOT completed my family. | |
| ☐ My sex life has suffered. | OR | ☐ I have not been able to have an orgasm, or it is very difficult. | |

**Habits:**

☐ I smoke cigarettes or cigars_____per day. ☐ I use e-cigarettes_____a day. ☐ I use caffeine_____a day.

☐ I drink alcoholic beverages_____per week. ☐ I drink more than 10 alcoholic beverages a week.

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# MALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

**Drug allergies**

Drug allergies:_____ If yes, please explain: _____

Have you ever had any issues with local anesthesia? ☐ Yes ☐ No Do you have a latex allergy? ☐ Yes ☐ No

Medications currently taking: _____

Current hormone replacement? ☐ Yes ☐ No If yes, what? _____

Past hormone replacement therapy: _____

**Family history:**

☐ Heart disease ☐ Diabetes ☐ Osteoporosis ☐ Alzheimer's/dementia ☐ Breast cancer ☐ Other_____

**Pertinent medical/surgical history:**

☐ Cancer (type):
Year:_____
☐ Elevated PSA
☐ Trouble passing urine
☐ Taking medicine for prostate or male-pattern balding
☐ History of anemia
☐ Vasectomy
☐ Erectile dysfunction
☐ Testicular or prostate cancer
☐ Prostate enlargement or BPH
☐ Kidney disease or decreased kidney function
☐ Frequent blood donations
☐ Non-cancerous testicular or prostate surgery
☐ Severe snoring
☐ Taking medicine for high cholesterol

**Birth Control Method:**

☐ Not applicable
☐ None - planning pregnancy in the next year
☐ Depend on partner's contraception
☐ Vasectomy
☐ Condoms
☐ Other: _____

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# MALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

**Medical history:**

- ☐ High blood pressure or hypertension
- ☐ Heart disease
- ☐ Atrial fibrillation or other arrhythmia
- ☐ Blood clot and/or a pulmonary embolism
- ☐ Depression/anxiety
- ☐ Chronic liver disease (hepatitis, fatty liver, cirrhosis)
- ☐ Arthritis
- ☐ Hair thinning
- ☐ Sleep apnea
- ☐ High cholesterol
- ☐ Stroke and/or heart attack
- ☐ HIV or any type of hepatitis
- ☐ Hemochromatosis
- ☐ Psychiatric disorder
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Lupus or other autoimmune disease
- ☐ Other _____

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# MALE HEALTH ASSESSMENT

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "none".

| Symptoms | None (0) | Mild (1) | Moderate (2) | Severe (3) | Very Severe (4) |
|---|---|---|---|---|---|
| Sweating (night sweats or increased episodes) | | | | | |
| Sleep problems (difficulty falling asleep, sleeping through the night, or waking up too early) | | | | | |
| Increased need for sleep or falls asleep easily after a meal | | | | | |
| Depressive mood (feeling down, sad, lack of drive) | | | | | |
| Irritability (mood swings, feeling aggressive, angers easily) | | | | | |
| Anxiety (inner restlessness, feeling panicky, feeling nervous, inner tension) | | | | | |
| Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina, or motivation) | | | | | |
| Sexual problems (change in sexual desire or in sexual performance) | | | | | |
| Bladder problems (difficulty in urinating, increased need to urinate) | | | | | |
| Erectile changes (weaker erections, loss of morning erections) | | | | | |
| Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise) | | | | | |
| Difficulties with memory | | | | | |
| Problems with thinking, concentrating, or reasoning | | | | | |
| Difficulty learning new things | | | | | |
| Trouble thinking of the right word to describe persons, places or things when speaking | | | | | |
| Increase in frequency or intensity of headaches or migraines | | | | | |
| Rapid hair loss or thinning | | | | | |
| Feel cold all the time or have cold hands or feet | | | | | |
| Weight gain, increased belly fat, or difficulty losing weight despite diet and exercise | | | | | |
| Infrequent or absent ejaculations | | | | | |
| **Total score (Mild 1-20/Moderate 21-40/Severe 41-60/Very severe 61-80)** | | | | | |