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New Patient History (male)

Name: _____ Date: _____

Date of Birth _____ Age _____ Occupation _____

Patient History (check all that apply)

- Decreased sex drive
- Weaker erections
- Longer time to climax
- Loss of spontaneous morning erections
- Infrequent or absent orgasms
- Fatigue and lack of energy
- Dry skin
- Snoring
- Insomnia
- Change in mood: anxiety and/or depression
- Shrinking testicles
- Recent Weight gain
- Declining mental ability and memory
- No result from erectile dysfunction medications
- Diminished strength and exercise tolerance
- Muscle shrinkage, loss of muscle tone
- Joints ache and/or new onset of arthritis symptoms
- Other _____

Medical History

Allergies to Medicines: _____

Current Medications: _____

Medical/Urological Exam in the Last Year:

Prostate exam and PSA:

Was normal

Was abnormal

New Patient History (page 2)

Medical Illnesses:

- High blood pressure
- Heart bypass surgery or stents
- Thyroid disease
- High cholesterol
- Prostate enlargement
- Urinary Problems
- Arthritis
- Depression/anxiety
- Cancer (type): _____ Year: _____

Past Medical History:

- I have had testicular or prostate cancer
- I have an elevated PSA
- I have trouble passing urine or take Prostate or Urinary Medication
- I have chronic liver disease (e.g., hepatitis, fatty liver, cirrhosis)
- I have diabetes
- I have had a stroke and/or heart attack
- I have had a blood clot and/or a pulmonary embolism
- I have hemochromatosis (elevated red blood cell count)

Past Surgical History: None Yes (please specify below)

Type	Date
_____	_____
_____	_____
_____	_____

Social:

- I have completed my family
- I want to be sexually active
- I am married or in a committed relationship (with male or female): _____
- I am sexually active (with male, female, or both): _____

Habits:

- I smoke cigarettes
- I drink more than 10 drinks of alcohol per week
- I am a recovering alcoholic or substance abuser
- I use or have used marijuana in the past year
- I use or have used cocaine or other illegal drugs in the past year

New Patient History (page 3)

Forms of Testosterone Hormone Therapy I have used and results:

Other problems or concerns not listed in this questionnaire:

Your Goals:

- I am here for Testosterone Hormone Pellet Therapy
- I would like to know more about other forms of Bio-identical testosterone hormone replacement
- Other: _____

Signature: _____ Date _____