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Pasadena Pellet Therapy

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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 _____