MORE T CLINICS

Male New Patient Intake

Patient Name: _____	**DOB:** _____	**DOV:** _____
Office Use Only:		
Ht: _____ **in** **Wt:** _____ **lbs.**	**Waist Circumference:** _____	
BP: _____ **/** _____	**HR:** _____	

Please circle the symptoms that describe what you are feeling:

- Breast discomfort
- Decrease mental sharpness
- Decreased concentration
- Decreased libido
- Decreased spontaneous erections
- Enlarged or "swollen" breasts
- Fatigue
- Feeling burnt out
- Hot flushes
- Inability to lose weight
- Loss of axillary or pubic hair
- Low motivation levels
- Mood fluctuations
- Noticeable decrease in testicular size
- Unusual sweating
- Weight gain
- None

Wellness: Do you have any of the following: (circle all that apply)

- Abnormal blood sugar
- Abnormal cholesterol
- Autoimmune diseases
- Blood sugar controlled with medications
- Cholesterol controlled with medications
- Constipation
- Decreased stamina
- Excess abdominal fat
- Food cravings
- Gas/Bloating
- Indigestion
- Irritable bowels
- Memory loss
- Pigmented skin folds
- Regular use of medication
- Slow wound healing

- Snoring while sleeping
- Sugar cravings
- Susceptibility to infections
- Vein problems
- Waist size greater than 40 inches
- None

Sleep information: Please circle any pertinent symptoms below:

- Abrupt night time awakenings accompanied by shortness of breath
- Attention problems
- Difficulty going to sleep
- Difficulty staying asleep
- Excessive daytime sleepiness
- Episodes where someone has witnessed you stop breathing during sleep
- Loud snoring
- Morning headaches
- None

How long have the above symptoms been occurring? (Circle one)

- Less than 1 year
- Approximately 1 year
- 2-3 years
- 4-5 years
- > 5 years

How would you describe these symptoms, and their effect on your quality of life? (Circle one)

- Mild
- Moderate
- Severe

Do any of the below improve your symptoms? (Circle any that apply)

- Caffeine
- Exercise
- Sleep
- Testosterone
- Testosterone boosters
- Other
- None

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What is the duration of your symptoms/timing? (Circle one)

- All day/constant
- In the morning only, then improves as the day goes on
- The afternoon seems to be the worst time of day for my symptoms
- Variable

Past Medical History: (circle all that apply)

- Abnormal liver functions
- Acid reflux
- AIDS
- Anemia
- Anxiety (treated with medications)
- Chronic kidney disease
- Cotton seed allergy
- Depression (treated with medications)
- Diabetes type I
- Diabetes type II
- Enlarged prostate (BPH)
- Grape seed allergy
- Hemochromatosis
- High blood pressure
- High cholesterol (treated with medications)
- High cholesterol (untreated)
- History of mumps
- History of prostate cancer
- HIV
- Hyperthyroidism
- Hypogonadism
- Hypothyroidism
- Inability to father children despite unprotected sexual relations for more than 1 year
- Obesity
- Peripheral vascular disease
- Prior testosterone replacement/use
- Sleep apnea (treated)
- Sleep apnea (untreated)
- Snoring
- None

Have you had any of the following cardiac disorders/events: (Circle all that apply)

- Angina
- Aortic valve disorder
- Blood clot (either DVT or pulmonary embolism)
- Cardiac arrhythmia (Atrial fibrillation/flutter, Ventricular tachycardia, etc.)
- Cardiac conduction event/disorder (bundle branch block, AV block)
- Cardiomyopathy
- Coronary artery bypass graft surgery (CABG)
- Endocarditis
- Heart attack
- Heart failure
- Mitral valve disorder
- Pericarditis
- Peripheral vascular disease
- Stroke
- None

Past Surgical History: (circle all that apply)

- Gastric bypass
- Gastric sleeve
- Orchiectomy
- Other stomach surgery
- Other testicular surgery
- Pituitary tumor removal
- Thyroid biopsy
- Thyroid removal
- Varicocele/hydrocele repair
- Vasectomy
- Other:
- None

Past Family History: (circle all that apply)

- Breast cancer (mother or sister)
- Breast cancer (other)
- Delayed puberty
- Diabetes
- Heart attack
- Hypothyroidism
- Prostate cancer (father or brother)
- Prostate cancer (other)
- Reproductive disorder

- Stroke
- None

Marital Status: (circle one)
Married Divorced Single Widowed

Do you desire current or future fertility? Do you wish to have any/more children? (Circle one)
Yes No

What is your occupation?

_____

Do you use tobacco?

- Cigarettes
- Cigars
- Dip/Snuff/ Chewing tobacco
- Former smoker Quit?_____

Do you drink alcohol? **Yes** **No** If so, how many drinks per week? _____

Do you Exercise? **Yes** **No** If so how many days per week? _____

Do you follow any particular diet? Low Glycemic Paleo Atkins Low Fat Other: _____

When was your last comprehensive (annual) physical? _____

When was you last digital prostate exam, to evaluate the prostate? _____

Please list any drug allergies below:

No known drug allergies or _____

Please list any medications and/or supplements you are taking below:

_____

Have you had or presently on hormone therapy? If you have, what type and what are the dates?

Testosterone (creams, gels, injections, pellets): _____ DHEA: _____

Progesterone: _____ Pregnenolone: _____

Growth Hormone: _____ Thyroid Hormone: _____

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Review of Systems: (Please circle all that apply)

- **Cardiovascular:** Chest pain/pressure Palpitations Pain in the lower legs with walking Fainting spells Dizziness
- ***Chest:*** Nipple tenderness Breast enlargement
- ***Constitutional:*** Abnormal weight gain Abnormal weight loss Decreased appetite Fatigue Night sweats
- ***Ear/Nose/Throat*****:** Hearing loss Ringing in ears Altered sense of smell
- **Endocrine:** Decreased sex drive Hot/cold intolerance Appetite change Excessive thirst
- ***Eyes*****:** Blurry vision Double vision Visual disturbances
- ***Gastrointestinal*****:** Swallowing difficulties Heartburn Abdominal pain Persistent nausea Vomiting
- ***Genitourinary*****:** Urinary frequency Frequent Night time urination Urinary urgency Urinary hesitancy Dribbling after urination Pain with urination Erectile dysfunction Blood in urine
- ***Immune/Allergy*****:** Hives
- **Integumentary:** Suspicious skin lesions Recurrent rashes Acne
- ***Musculoskeletal*****:** Joint pain Muscle pain Muscle Weakness
- ***Neurological*****:** Frequent headaches Arm and/or leg weakness Difficulty with speech Chronic pain
- ***Psychiatric:*** Depressed mood Anxiety Irritability Insomnia Low self-confidence
- ***Respiratory:*** Persistent nonproductive cough Wheezing Shortness of breath

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Exam:

General: The patient is pleasant and well groomed who is In no acute distress.

Skin: no rashes, no lesions noted Other: _____

Head: Atraumatic and normocephalic. Oro-pharynx is clear, oral mucous membranes are moist.

Other: _____

Eyes: Conjunctivae and sclera are clear bilaterally.

Other: _____

Ears: External ears without deformity. Canals clear bilaterally.

Other: _____

Nose: Nares patent bilaterally. No masses noted.

Neck: Supple, no masses, FROM c-spine. No thyromegaly,

Other: _____

Lungs:: CTA bilat with normal respiratory effort. No rales, rhonchi or wheezing.

Other: _____

Heart: RRR, no murmurs, no rubs, no gallops. No edema bilat LE's.

Breast (chest): Symmetrical without discharge or deformity. No masses palpated.

GI: Soft, nontender, bowel sounds heard in all 4 quadrants and normoactive. No masses, no hepato or splenomegaly

Other: _____

Extremities: Normal gait, FROM x 4 extremities with no pain. Extremities symmetric w/no joint effusions.

Other: _____

Skin: Normal in color and in texture. No rashes or abnormal lesions noted.

Neuro/Psych: Appropriate affect. A&O x 3 with no evidence of agitation, or abnormal response.

Other: _____

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Assessment:

Chronic Fatigue Decreased Libido Abnormal Weight Gain Obesity Hypogonadism (symptomatic)

Sleep apnea: Reportedly stable, monitored, and treated Sleep apnea: Poorly controlled, reevaluate

Hypothyroidism: Reportedly stable, monitored, treated Hypothyroidism: Not well controlled

Other: _____

Plan:

Labs drawn today:

Male Standard Panel Male Comprehensive Panel

Other: _____

- Pt to return for a second AM testosterone and SHBG test, and a full lab discussion with all available labs, and discussion of hormone therapy options if appropriate
- AUA IPSS filled out today. The score was noted to be _____. This value is within normal limits, and we will ask the patient to fill this form out again in 6 months.
- Epworth Sleep Score filled out today. The score was noted to be _____. This value is within normal limits abnormal borderline.
- Medication import history consent signed by patient.
- Medical records release form signed and authorized record release to self.
- Pt filled out a medical records request, and it was faxed to his present treating provider _____ _____ , at the fax number: _____. We will review these with the patient once they are available.
- New patient discussion information here:_____ _____
- Other: _____ _____ _____
- Other labs: _____ due: _____
- Other Rx written today: _____
- Discussion of low glycemic diet options and exercise modalities for optimum health and weight loss.

Signed: _____ Date: _____