6010 Executive Blvd Ste #506
Rockville, Maryland 20852
P: 301-231-5055
F: 301-231-7217

TESTOSTERONE INTAKE FORM

NAME: _____ DATE:_____

ADDRESS:_____ CITY:_____ STATE:_____

ZIP CODE: _____ CELL#:_____ HOME#_____

SOCIAL SECURITY#_____ DATE OF BIRTH:_____

DRIVERS LICENSE NUMBER:_____ STATE:_____

EMAIL ADDRESS:_____

MARITAL STATUS: ( ) SINGLE ( ) MARRIED ( ) DIVORCED ( ) WIDOWED ( ) SEPERATED

EMPLOYER: _____ WORK#:_____

BUSINESS ADDRESS: _____

CITY:_____ STATE:_____ ZIP: _____

EMERGENCY CONTACT: _____ PHONE#:_____

HOW WERE YOU REFERRED TO OUR FACILITY?: ( )WORD OF MOUTH ( ) INTERNET ( ) TV ADVERTISMENT ( ) REFERRAL

NAME OF REFERRAL _____

PATIENT NAME (PRINT NAME): _____ DATE:_____

PATIENT SIGNATURE: _____ DATE:_____

WITNESS NAME (PRINT NAME): _____DATE:_____

WITNESS SIGNATURE: _____DATE:_____

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Health History Questionnaire

Patient Name: _____ DOB:_____ Date:_____

Occupation:_____

Primary Care Physician(PCP)_____ Phone#:_____

Date of last physical exam: _____

Personal Health History:

(Please Circle All That Apply)

General	Diabetes	High Cholesterol	Unwanted Weight Loss
Cancer	Personal History of Cancer	Family History of Cancer	
Cardiovascular	Heart Failure	Chest Pain	Heart Murmur
	Vascular Disease	Blood Clots	Edema
	Hypertension		
Respiratory	Sleep Apnea	Shortness of Breath	Asthma
	Bronchitis	Pneumonia	Allergies
Gastrointestinal	Lactose Intolerance	Gall Bladder	Gall Stones
	Chronic Diarrhea	Chronic Constipation	
Genitourinary	Prostate Cancer	Family History of Prostate Cancer	Overactive Bladder
	Painful Urination	Decreased urinary force	On/Off Urine Flow
	Enlarged Prostate (BPH)	Blood in Urine	Kidney/Bladder History
Infection	Kidney Bladder	Liver	Other
Psychiatric	History of Depression	Personality Disorder	Other

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Medication Information/History

Pharmacy Name: _____ Pharmacy Number: _____

Please list your prescribed drugs and any over the counter drugs, such as vitamins and inhalers. Please make sure to include any anti-anxiety or anti-depressant medications.

Drug Name: _____ Dosage:_____ Frequency:_____
Taken For: _____

Drug Name: _____ Dosage:_____ Frequency:_____
Taken For: _____

Drug Name: _____ Dosage:_____ Frequency:_____
Taken For: _____

Drug Name: _____ Dosage:_____ Frequency:_____
Taken For: _____

Please list any known allergies:
_____
_____
_____
_____

Please list a history of surgeries:

Year:_____ Surgery/Reason:_____

Year:_____ Surgery/Reason:_____

Year:_____ Surgery/Reason:_____

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Health Habits Questionnaire

Please check all that apply

Exercise: ( ) Sedentary(No Exercise) ( ) Mild Exercise ( ) Occasional Vigorous Exercise ( ) Regular Vigorous Exercise

Describe the type of exercise and frequency (resistance training, cardiovascular, number of times per week)

_____
_____
_____
_____

Have you ever used Testosterone (prescribed or otherwise) or any other anabolic steroids in the past?) Please list the name of medications below.

_____
_____
_____
_____

Rate your quality of sleep: 1(Worst)-10(Best)

1 2 3 4 5 6 7 8 9 10

Alcohol: ( )Yes ( )No If yes, how many drinks per week? _____

Tobacco/Cigarettes ( )Yes ( )No If yes, how many times per week? _____

Illicit Drug Use ( ) Yes ( )No If yes, please explain:

_____
_____
_____

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SYMPTOMS OF LOW TESTOSTERONE

Decreased Concentration ( )Yes ( )No

Difficulty learning new things ( )Yes ( )No

Memory Loss ( )Yes ( )No

Moodiness ( )Yes ( )No

Depression ( )Yes ( )No

Increasing Fatigue ( )Yes ( )No

Decreasing energy ( )Yes ( )No

Daytime Sleepiness ( )Yes ( )No

Poor sleep habits ( )Yes ( )No

Erectile Dysfunction ( )Yes ( )No

Checked Testosterone Levels Previously? ( )Yes ( )No

Used Testosterone Previously? ( )Yes ( )No If yes, please state
Date_____ Type:_____ Usage:_____

Patient Name(Print): _____ DOB:_____

Patient Signature: _____ Date:_____