Patient Information

Name: _____
Last First Middle

Street Address: _____

City: _____ State: _____ ZIP: _____

Telephone: _____ Cell Phone: _____

Email address: _____

Marital Status: (circle) Single Married Divorced Separated Widow/Widower

Please provide information for someone we may contact in case of an emergency.

Name: _____

Telephone or cell phone: _____

Relationship: _____

Signature: _____

Date: _____

What is the reason for your visit today? Please be as specific as possible.

_____

_____

_____

_____

_____

How did you hear about us?

_____

_____

_____

Do you presently take any hormonal or herbal therapy? Please check all that apply.

◯ Pills _____
medication and dose

◯ Creams _____
medication and dose

◯ Gels _____
medication and dose

◯ Injections _____
medication and dose

◯ Pellets _____
medication and dose

◯ Other / Herbals _____
medication and dose

Current Medications

Drug name	Dose	Prescribing Physician
Drug name	Dose	Prescribing Physician
Drug name	Dose	Prescribing Physician
Drug name	Dose	Prescribing Physician
Drug name	Dose	Prescribing Physician
Drug name	Dose	Prescribing Physician

Drug Allergies _____

Medical Problems

_____

_____

Previous Surgeries

_____

_____

Social History

Do you smoke tobacco? Yes ◯ No ◯

If yes, how much do you smoke? _____

Do you use recreational drugs? Yes ◯ No ◯

If yes, please list the drugs used: _____

Do you drink alcohol? Yes ◯ No ◯

How many drinks per week: _____

Have you ever had an STD? Yes ◯ No ◯

If yes, please list: _____

Symptom Check List

	Frequently	Rarely	Never
Mood swings	◯	◯	◯
Anxiety	◯	◯	◯
Irritability	◯	◯	◯
Migraines	◯	◯	◯
Memory loss	◯	◯	◯
Foggy thinking	◯	◯	◯
Muscle loss	◯	◯	◯
Poor response to exercise	◯	◯	◯

Do you have any sexual dysfunction? If so, please explain:

_____

_____

_____

_____

_____

Prostate Exam Waiver for Hormonal Pellet Therapy

I voluntarily choose to undergo implantation of subcutaneous Testosterone pellet therapy at the Cincinnati Center for Hormonal Pellet Therapy.

◯ I am current with my prostate exams.

Date of last prostate exam: _____

Result of last prostate exam: Normal ◯ Abnormal ◯

◯ For today's visit, I **do not** have a prostate exam to report for the following reason:

- ◯ My decision not to have one.
- ◯ My physician has not ordered one or it is not indicated because of my age.

I am aware that prostate exams are integral in the detection of early prostate cancer. If I am unable to provide the results of a current prostate exam, I acknowledge that I bear full responsibility for any personal injury or illness, accident, risk or loss (including death and/or prostate issues) that may be sustained if I do not routinely get prostate exams.

_____ _____

Signature Date