MALE PATIENT HEALTH SUMMARY

SWAN MEDICAL
PETER CASTILLO MD, FACOG, FPMRS

Date _____ Name _____ D O B _____

What is the main reason you are here to see the provider today?	1. How long have you experienced each problem? 2. Any prior treatment you had for this?

List any medical problems or health conditions you have:	Year diagnosed:	List any surgeries, procedures or hospitalizations you have had since childhood	Year (if known)

Family History:

Any family history of:	Relationship
( ) High cholesterol	
( ) High blood pressure	
( ) Heart disease	
( ) Diabetes	
( ) Stroke and/or heart attack	
( ) Osteoporosis	
( ) Urinary problems	
( ) Alzheimer's/dementia	
( ) Renal Disease	
( ) Chronic liver disease	
( ) Arthritis	
( ) Cancer (list type)	
( ) Other:	

Activity:
Do you exercise regularly?
( ) 3x a week or more
( ) Occasionally
( ) Rarely

Habits:
( ) I smoke cigarettes or cigars ____ per day
( ) I use caffeine ____ a day
( ) I drink alcoholic beverages ____ per week
Do you use recreational drugs?
( ) Yes: Types/comments: _____

Allergies
List known allergies along with the type of reaction you experience.

Have you ever had any issues with local anesthesia? ( ) Yes ( ) No
Do you have a latex allergy? ( ) Yes ( ) No

Medications
Please list all of the medications you currently take, or any **hormone replacement**. List the dosage and how often you take it.

Medication Name (e.g Advil)	Strength (e.g 100mg)	Dosage (e.g 1 tablet once a day)

Social History:

( ) I am sexually active OR ( ) I want to be sexually active ( ) I do not want to be sexually active
( ) I have completed my family OR ( ) I have NOT completed my family
( ) My sex life has suffered OR ( ) I have not been able to have an orgasm or it is very difficult

Pertinent Medical/Surgical History:

( ) Elevated PSA
( ) Trouble passing urine
( ) Erectile dysfunction
( ) Severe snoring
( ) Taking medicine for prostate or male-pattern balding
( ) Non-cancerous testicular or prostate surgery
( ) Testicular or prostate cancer
( ) History of anemia
( ) Kidney disease or decreased kidney function
( ) Frequent blood donations
( ) Prostate enlargement
( ) Vasectomy

Medical Illnesses:

( ) High blood pressure
( ) Stroke/heart attack
( ) High Cholesterol
( ) Hair thinning
( ) Heart disease
( ) Stroke and/or heart attack
( ) Blood clot and/or a pulmonary embolism
( ) Hemochromatosis
( ) Arrhythmia or atrial fibrillation
( ) Any form of Hepatitis or HIV
( ) Lupus or other autoimmune disease
( ) Frequent blood donation or history of anemia
( ) Fibromyalgia
( ) Chronic kidney disease
( ) Dialysis
( ) Sleep apnea
( ) Chronic liver disease
( ) Diabetes
( ) Thyroid disease
( ) Depression/anxiety
( ) Psychiatric disorder
( ) Arthritis
( ) Cancer (type) : _____

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MALE HORMONE ASSESSMENT

Date _____ Name _____ D O B _____

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "never"

Symptoms	**Never** (0)	**Mild** (1)	**Moderate** (2)	**Severe** (3)	**Very Severe** (4)
Increased need for sleep or falls asleep easily after meal					
Sweating (night sweats or increased episodes of sweating)					
Sleep problems (difficulty falling asleep, sleeping through the night or waking up too early)					
Depressive mood (feeling down, sad, lack of drive)					
Irritability (mood swings, feeling aggressive, angers easily)					
Anxiety (inner restlessness, feeling panicky, nervous, inner tension)					
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation					
Sexual problems (change in sexual desire, sexual activity and/or orgasm and satisfaction*)*					
Bladder problems (difficulty in urinating, increasing need to urinate, incontinence					
Erectile changes (weaker erections, loss of morning erections)					
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)					
Difficulties with memory					
Problems with thinking, concentrating or reasoning					
Difficulty learning new things					
Trouble thinking of the right word to describe persons, places or things when speaking					
Increase in frequency or intensity of headaches and migraines					
Rapid hair loss or thinning					
Weight gain, increased belly fat, or difficulty losing weight despite diet and exercise					
Feel cold all the time or have cold hands or feet					
Infrequent or absent ejaculations					

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CONSENT TO EXAMINATION/PROCEDURES

I _____ understand and consent to examination by Dr. Peter Castillo or designee including procedures vital to the evaluation.

_____ _____

Patient Signature Date