PAGE 1, MALE BIH HEALTH HISTORY

PLEASE TAKE A MOMENT TO COMPLETE OUR MALE HEALTH HISTORY FORM

Today's Date: _____

Last Name: _____ **First Name:** _____ **MI:** _____

Nick Name:_____ **Sex (please circle one):** Female Male Transgender

Date of Birth: _____ **Age:** _____

Street Address: _____ **P.O. Box Number (if applicable):** _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Numbers: **Home:** _____ **Cell:** _____ **Work:** _____

Preferred phone number for contact: □ Home □ Cell □ Work

Email Address (Please print legibly):

_____

YOUR EMAIL ADDRESS IS OUR HORMONE DEPARTMENT'S PREFERRED MEANS OF CONTACTING YOU

May we send you text appointment reminders? □ YES □ NO
May we send you an email for appointment reminders/medical/additional scheduling information? □ YES □ NO
…for our monthly specials/special event information? □ YES □ NO □ I do not wish to receive these notifications
May we send you regular mail? □ YES □ NO
May we leave you a voicemail? □ YES □ NO
May we leave a message with someone else? □ YES □ NO

Occupation: _____

Marital Status: □ Married □ Divorced □ Single/Never Married □ Widowed □ Living with Significant Other

Ethnicity: □ Caucasian (Not Hispanic or Asian) □ Hispanic □ Asian □ Black/African-American □ Other _____

Language: □ English □ Spanish □ Other _____

Emergency Contact Information:

Name: _____ Relationship: _____ Phone: _____

Who may we release *medical* or *appointment information* to?

Name: _____ Relationship: _____ Phone: _____

Preferred Pharmacy: _____

Location: _____ Phone: _____

Preferred Lab:_____ Location: _____

Physician Name:_____ Phone: _____

How did you hear of Allura / who may we thank for referring you? (Please check all that apply):

□ Internet □ Magazine □ Newspaper □ Billboard □ Mailer □ Staff Member □ Physician □ Other

□ Allura client / Family Member / Friend: _____

□ Physician: _____

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We are honored that you have chosen Allura Skin, Laser, and Wellness Center.
Please state the reasons for your visit: _____

_____

MEDICAL HISTORY:
Please mark if you or a family member has or has ever had any of the following conditions:

You		Condition	Family	
Y	N	Diabetes	Y	N
Y	N	Hypertension	Y	N
Y	N	Heart Disease	Y	N
Y	N	High Cholesterol	Y	N
Y	N	Heart Murmur	Y	N
Y	N	Rheumatic Fever	Y	N
Y	N	Atrial Fibrillation	Y	N
Y	N	Stroke	Y	N
Y	N	Bleeding Disorders	Y	N
Y	N	Blood Clots	Y	N
Y	N	Polycythemia/Hemochromatosis	Y	N
Y	N	Varicose Veins	Y	N
Y	N	Leukemia/Lymphoma/MM	Y	N
Y	N	Liver Disease	Y	N
Y	N	Hepatitis A__ B__ C__	Y	N
Y	N	HIV	Y	N
Y	N	Hypothyroid/Hashimoto's	Y	N
Y	N	Hyperthyroid/Graves' Disease	Y	N
Y	N	Other thyroid problems	Y	N
Y	N	Asthma/Emphysema/COPD	Y	N
Y	N	Chronic Bronchitis	Y	N
Y	N	Kidney Disease	Y	N
Y	N	Crohn's/Celiac Disease	Y	N
Y	N	Lactose/Gluten Intolerance	Y	N
Y	N	Irritable Bowel	Y	N
Y	N	Colon Polyps	Y	N
Y	N	Breast Cancer	Y	N
Y	N	Colon Cancer	Y	N
Y	N	Lung Cancer	Y	N
Y	N	Ovarian Cancer	Y	N
Y	N	Prostate Cancer	Y	N
Y	N	Rectal Cancer	Y	N
Y	N	Anxiety	Y	N
Y	N	Depression	Y	N
Y	N	Psychiatric Disorder: Bi Polar	Y	N
Y	N	Auto Immune Disorders: Lupus	Y	N
Y	N	Rheumatoid Arthritis	Y	N
Y	N	Scleroderma	Y	N
Y	N	Osteopenia/Osteoporosis	Y	N
Y	N	Arthritis	Y	N
Y	N	Chronic Pain/Fibromyalgia	Y	N
Y	N	Alzheimer's Dementia	Y	N
Y	N	Multiple Sclerosis	Y	N
Y	N	Parkinson's	Y	N

Weight: _____ **Height:** _____

Drug Allergies and/or Reactions:
_____
_____

Previous Surgeries or Procedures:
_____
_____
_____
_____
_____

Hospitalizations or Treatments:
_____
_____
_____
_____

Current Medications and Doses:
_____
_____
_____
_____
_____
_____
_____

Vitamins, Supplements and Herbs:
_____
_____

Do you take Aspirin or other anti-inflammatories on a daily basis? □ YES □ NO

Social History:
Do you smoke? □ YES □ NO
If yes, number per day ____ How many years? ____
Recreational drug use? □ YES □ NO
Do you drink Alcohol? □ YES □ NO
If yes, number of drinks per week? ____
How many days per week do you exercise? ____

_____
Patient Signature **Date**

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ALLURA skin, laser & wellness clinic

TODAY'S DATE: _____

SYMPTOM	Y	N	SYMPTOM	Y	N	SYMPTOM	Y	N
Anxiety			Decrease in energy			Mood Swings		
Depression			Decrease in sexual desire			Muscle and/or joint pain		
Difficulty concentrating			Decrease in sexual frequency			Weight gain in recent 2 years		
Fatigue			Decrease in sexual performance			Wt loss in the previous 2-6 mo.		
Fogginess in thinking			Decrease in muscle mass			Sleep Problems		
Headaches/Migraines			Loss of motivation			Poor recovery from exercise		
Irritability			Memory Loss			Poor response to exercise		

PROSTATE AND TESTICULAR HISTORY:

Are you currently sexually active? □ YES □ NO

Age of 1st Intercourse:_____

Please check your sexual orientation:
__ Heterosexual __ Homosexual __ Bisexual

Have you fathered any children? □ YES □ NO
If yes, how many children? _____

Have you been treated for any Sexually Transmitted Disease? Please check all that apply:
__ Chlamydia __ Gonorrhea __ Herpes
__ Syphilis __ Warts __ Other

Have you ever been tested for HIV?
If yes, when and what were the results?
Date: _____ ___ Positive ___ Negative

Have you ever had a sperm count? □ YES □ NO
What were the results? _____

Have you ever had Testicular Cancer? □ YES □ NO
If yes, any treatment? _____

Have you ever been told your prostate was enlarged?
If yes, any treatment? _____

Have you ever had prostatitis or any prostate problem?

□ YES □ NO Describe: _____

Have you ever had Prostate Cancer? □ YES □ NO
If yes, when and describe treatment:
Date: _____ Treatment: _____

_____

Have you ever had blood in your urine? □ YES □ NO

Do you have difficulty urinating? □ YES □ NO

Do you urinate frequently during the night? □ YES □ NO
If yes, how many times? _____

When was your last rectal exam to check your prostate?
Date: _____

SEXUAL HISTORY:

Do you initiate intercourse? □ YES □ NO

Do you achieve orgasm? □ YES □ NO

Is intercourse satisfying? □ YES □ NO

Do you suffer from premature ejaculation?
If yes, any treatments? _____

Do you suffer from erectile dysfunction?
If yes, any treatments? _____

Is your sex drive similar to how it was 5 years ago?
□ YES □ NO

How often do you have intercourse per wk? ____
Per month? ____

Are you currently using or have used any form of Testosterone? □ YES □ NO
If yes, what type? _____
Any other concerns that you would like to discuss?
_____

_____
Patient Signature Date

_____
Provider Signature Date

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TODAY'S DATE: _____

AUTHORIZATIONS (please initial):

_____ I consent to the taking of photographs for the purpose of documentation and future comparison.

_____ I authorize the release of information to/from my Primary Care Physician or Specialist if deemed necessary for the treatment.

_____ **I understand that my insurance company will not cover any of the procedures performed.**

_____ **Payments for all procedures or services are to be paid at the conclusion of each visit**.

_____ I understand that procedure packages are non-transferable.

I authorize that the above information is up to date and correct to the best of my knowledge.

_____ _____

Client Signature (Parent/Guardian if client is a minor) Date

_____ _____

Provider Signature Date

Thank you for completing this paperwork!