



## SEXUAL HISTORY

1. Age of first sexual contact: \_\_\_\_\_
2. Are you sexually active?  YES  NO
3. Do you have a history of Sexually Transmitted Diseases?  YES  NO  
If yes, please list: \_\_\_\_\_
4. Have you had a sperm count?  YES  NO  
Results: \_\_\_\_\_
5. Have you had the Mumps?  YES  NO  
Date: \_\_\_\_\_
6. Have you had Testicular Cancer?  YES  NO  
Date: \_\_\_\_\_
7. Do you have Prostate Problems?  YES  NO  
If yes, please describe: \_\_\_\_\_
8. Have you had blood in your urine?  YES  NO  
If yes, when & treatment: \_\_\_\_\_
9. Have you had any bladder or kidney problems?  YES  NO  
If yes, when & treatment: \_\_\_\_\_
10. Do you have erectile dysfunction?  YES  NO  
If yes, please describe: \_\_\_\_\_
11. Do you have:
  - Fatigue?  YES  NO
  - Decrease of memory?  YES  NO
  - Decrease of energy level?  YES  NO
  - Decrease of sexual drive?  YES  NO
12. Do you suffer from:
  - Anxiety?  YES  NO
  - Irritability?  YES  NO
  - Mood swings?  YES  NO
  - Migraines?  YES  NO
13. How have you dealt with these symptoms?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
14. Do you initiate intercourse?  YES  NO
15. Is intercourse satisfying?  YES  NO
16. Do you achieve orgasm?  YES  NO
17. Do you suffer from premature ejaculation?  YES  NO
18. How often do you have intercourse?  
\_\_\_\_\_
19. Is your sex drive the same as it was five years ago?  YES  NO  
Describe: \_\_\_\_\_

20. List any other sexual dysfunctions:

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21. Have you experienced weight gain in the last one-two years?  YES  NO  
If yes, please describe: \_\_\_\_\_

22. Have you lost greater than 10 pounds in less than a month?  YES  NO  
If yes, why? \_\_\_\_\_

23. Are you HIV positive?  YES  NO  
If yes, when? Describe: \_\_\_\_\_

24. Have you ever been tested for AIDS?  YES  NO  
Results? \_\_\_\_\_

25. Have you fathered any children?  YES  NO  
If yes, how many? \_\_\_\_\_

26. Have you had your Testosterone level taken?  YES  NO

27. List current medications:

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28. Sexual Orientation?

Heterosexual

Homosexual

Bisexual

### PAST MEDICAL HISTORY

1. Do you have diabetes?  YES  NO

2. Do you have/had hypertension?  YES  NO

3. Do you have heart disease?  YES  NO

4. Do you have a heart murmur?  YES  NO

5. Do you have/had kidney disease?  YES  NO

6. Have you ever been treated for psychiatric problems?  YES  NO

7. Have you ever had rheumatic fever?  YES  NO

8. Do you have mitral valve prolapse?  YES  NO

9. Have you ever had a urinary tract infection?  YES  NO

10. Have you ever had hepatitis/liver disease?  YES  NO

11. Have you ever had varicosities/phlebitis?  YES  NO

12. Do you have any thyroid problems?  YES  NO

13. Have you had any major accidents?  YES  NO

14. Have you ever had any blood transfusions?  YES  NO

15. Do you have asthma/lung disease?  YES  NO

16. Do you have lupus?  YES  NO

17. Do you have arthritis?  YES  NO

18. Do you have any Drug Allergies?  YES  NO

If yes, please list: \_\_\_\_\_

19. Please list any surgeries: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

20. Please list any other operations/hospitalizations (include year & reason):

\_\_\_\_\_

\_\_\_\_\_

21. Have you had any anesthesia complications:  YES  NO

If yes, please list: \_\_\_\_\_

22. Have you ever been anemic?  YES  NO

23. Do you have an Internist or Family Doctor?  YES  NO

Please list name, phone number: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

24. Have you had your cholesterol checked?  YES  NO

If yes, date last checked? \_\_\_\_\_

Was it normal?  YES  NO

### SOCIAL HISTORY

1. Do you smoke cigarettes?  YES  NO

If yes, number per day? \_\_\_\_\_ Number of years? \_\_\_\_\_

2. Do you use street drugs?  YES  NO

3. Do you drink alcohol?  YES  NO

If yes, how much per day? \_\_\_\_\_