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PROGRESSIVE WOMENS HEALTH, PLLC
ASIA MOHSIN, MD

MALE MEDICAL HISTORY

Today's Date: _____
Last Name: _____ First Name: _____ Date of Birth: _____
Pharmacy Name/Location: _____ Pharmacy Phone #: _____
Allergies to Medications, Foods, or Substances (e.g. Latex): _____
Do you currently have any of the following advanced directives? □DNR □Living Will □Organ Donor □Power of Attorney
Height: _____ Previous Weight: _____

Reason for this visit:

Medications, OTC, Vitamins:

PAST MEDICAL HISTORY

Please complete for your first visit at our office. This form is confidential. Please check "Yes" or "No" if you currently or have you ever had any of the following conditions?

Yes	No	
☐	☐	Depression or any psychiatric illness
☐	☐	Headaches/migraines
☐	☐	Blood clots (i.e. DVT, PE)
☐	☐	Liver disease
☐	☐	Diabetes, ☐Type I ☐Type II
☐	☐	Cancer – Type _____
☐	☐	High blood pressure
☐	☐	Stroke
☐	☐	Ulcers
☐	☐	Persistent Urinary Tract Infections
☐	☐	Arthritis or joint problems
☐	☐	Osteoporosis
☐	☐	Lung disease (i.e. asthma, COPD)
☐	☐	Heart disease – Type _____
☐	☐	Thyroid Disease
☐	☐	High cholesterol or lipids
☐	☐	Blood transfusion
☐	☐	Tuberculosis or other infections
☐	☐	Seizure disorder
☐	☐	Erectile/Testicular/Prostate problems – Type: _____
☐	☐	Other – Please list: _____

Yes	No	
☐	☐	Anemia
☐	☐	Breast discomfort, gynecomastia
☐	☐	Depressed mood
☐	☐	Diminished bone destiny
☐	☐	Diminished energy
☐	☐	Diminished muscle mass and strength
☐	☐	Diminished physical or work performance
☐	☐	Hot flashes, sweat
☐	☐	Impaired cognition
☐	☐	Incomplete or delayed sexual development
☐	☐	Increased body fat, body mass index
☐	☐	Increased fatigue
☐	☐	Infertility
☐	☐	Loss of body hair
☐	☐	Sexual symptoms (decreased libido, decreased spontaneous erection)
☐	☐	Very small testes

Last Name: _____ First Name: _____ Date of Birth: _____

FAMILY HISTORY

Do you have a history or family history of the following?

Yes	No	
□	□	Prostate Cancer
□	□	Testicular Cancer
□	□	Other – Any of the problems above?

_____

SOCIAL HISTORY

Do you use any of the following?

Yes	No		How much/often?
□	□	Alcohol	_____
□	□	Tobacco	_____
□	□	Caffeine	_____
□	□	Drugs	_____

SURGICAL HISTORY

Have you had any of the following procedures/exams?

Yes	No	
□	□	PSA
□	□	Prostate exam
□	□	Colonoscopy
□	□	Vasectomy
□	□	Sexually transmitted infections
□	□	Other – Please list: _____

HOSPITALIZATIONS

Have you ever been hospitalized and for what?

_____
_____
_____
_____
_____
_____
_____

QUESTIONAIRE

Yes	No	
□	□	Do you have any children
□	□	Do you plan to have more children
□	□	Do you currently have a partner who is pregnant and/or breastfeeding?
□	□	Have you used steroids in the past?
□	□	Do you currently use steroids?
□	□	Are you currently sexually active?
□	□	Do you use nitrates for chest pain?
□	□	Do you have trouble starting or maintaining an erection? If yes, have you used any medications for it and did you use? _____ Did it help? If no, please explain. _____
□	□	Have you ever used hormone replacement therapy? If yes, list medications, dose, directions, and duration of treatment. _____ Did you have any problems? If yes, please explain. _____
□	□	Do you exercise? If yes, please describe your routine. _____
□	□	Do you currently follow a special diet? If yes, please explain. _____
□	□	Do you have any sexual complaint like erectile dysfunction, low testosterone, or low desire? If yes, please explain. _____

Patient's Signature: _____ Date: _____