

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_\_

Preferred name: \_\_\_\_\_ Pronouns: \_\_\_\_\_

Sex: Female Male Gender \_\_\_\_\_ Marital Status: Single Married Partnered Divorced Separated Other

What is the one most important symptom or concern you would like addressed today? \_\_\_\_\_

Any other concerns if time allows? \_\_\_\_\_

Urological History: Have you ever had any of the following:

undescended testicles  injury to the testicles  hernia  bladder or prostate surgery

Have you ever had a vasectomy? YES/NO

Do you have problems urinating, starting stream or dribbling? YES/NO

Are you sexually active? YES/NO Method of contraception: \_\_\_\_\_ What is your sexual preference? \_\_\_\_\_

Do you have any problems with sexual relations/drive? YES/NO If Yes, explain \_\_\_\_\_

Do you have a problem with achieving/maintaining erections? YES/NO

Do you have any problems with ejaculation? YES/NO

Do you have children? YES/NO

Do you have a family member with a fertility problem? YES/NO

Have you ever had any of the following Sexually Transmitted Infections? (Please circle)

Genital Herpes      Chlamydia      Gonorrhea      HIV      HPV

Are you interested in HIV/STI testing? YES/NO

Do you use any tobacco products? YES/NO

Have you used any tobacco products in the past?

Please list: \_\_\_\_\_

Do you drink alcohol? YES/NO

Drinks per day/week \_\_\_\_\_

Do you use recreational drugs? YES/NO

Are you satisfied with your eating habits? YES/NO

Does your weight affect your self-esteem? YES/NO

Do you binge, purge or restrict? YES/NO

Do you exercise regularly? YES/NO

Have you ever been emotionally or physically abused? YES/NO

**In the past 2 weeks have you had little interest or pleasure in doing things or felt depressed or hopeless? YES/NO**

Have you ever been diagnosed with a mental illness? YES/NO

Please List all medications (including supplements) \_\_\_\_\_

\_\_\_\_\_

**Are you allergic to any medication(s)? YES/NO IF yes, explain** \_\_\_\_\_

\_\_\_\_\_

List any **surgery** history (Procedure & year) \_\_\_\_\_

Family History please indicate **who and at what age** any family members diagnosed with the following:

Diabetes \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Heart Attack \_\_\_\_\_

Stroke \_\_\_\_\_ Thyroid Disease \_\_\_\_\_ Breast Cancer \_\_\_\_\_

Cancer of Uterus and or Ovaries \_\_\_\_\_ Blood Clot/Blood Disorders \_\_\_\_\_

Seizures \_\_\_\_\_ Colon Cancer \_\_\_\_\_ Osteoporosis \_\_\_\_\_

Disordered Eating \_\_\_\_\_