INNOVATIVE HEALTH

General Information: MALE Date: _____

Name:_____ Age: _____ Who referred you to us? _____

Who is your primary care provider: _____ Who is your urologist? _____

What pharmacy do you use: _____ Location _____

What is the primary reason for your visit? _____

Do you require antibiotics before dental procedures? ☐ Yes ☐ No

Have you had a blood transfusion? ☐ Yes, Date: _____ ☐ No

Past Medical History:

Please check any problems below that you have had, or are currently experiencing:

☐ Acid Reflux/Heartburn	☐ Emphysema	☐ Kidney Disease	☐ Seizures
☐ Alcoholism	☐ Exposure to HIV/AIDS	☐ Kidney Stones	☐ Sleep Apnea
☐ Anemia	☐ Fibromyalgia	☐ Lung Disease (COPD)	☐ Stroke
☐ Anxiety Disorder	☐ Glaucoma	☐ Lupus Erythematosus	☐ Thyroid Disease
☐ Arthritis	☐ Heart failure	☐ Migraines	☐ Tuberculosis
☐ Colitis	☐ Hepatitis B	☐ Mitral Valve Prolapse	☐ Ulcers
☐ Deep Vein Thrombosis	☐ Hepatitis C	☐ Pancreatitis	☐ Prostate Cancer
☐ Depression	☐ High Blood Pressure	☐ Pneumonia	☐
☐ Diabetes	☐ High Cholesterol	☐ Pulmonary Embolus	☐
☐ Diverticulitis	☐ HIV	☐ Rash	☐
☐ Eating Disorder	☐ Interstitial Cystitis	☐ Raynaud's	☐
☐ Eczema	☐ Irritable Bowel Syndrome	☐ Seasonal Allergies	☐ Other Cancer

Date of Last Flu Vaccine:_____ Date of Last Pnuemonia Vaccine:_____ Other:_____

Past Surgical History:

Please check all previous surgeries you have had:

☐ Ablation (heart)	☐ Colonoscopy Date: _____	☐ Lung Surgery
☐ Angioplasty	☐ Cystocele Repair	☐ Lumpectomy
☐ Appendectomy	☐ Gall Bladder Surgery	☐ Kidney Stones
☐ Back Surgery	☐ Heart By-pass Surgery	☐ Thyroid Surgery
☐ Bladder Surgery or Cysto	☐ Hernia Surgery	☐ Tonsillectomy
☐ Cancer Chemo	☐ Hip Replacement	☐ Other:
☐ Cancer Removal Surgery Type: _____ Date: _____	☐ Knee Replacement	☐ Date: _____

Present Medications:

Please list or attach a list of all medications, supplements and over ther counter meds you are presently taking and dosage: _____

_____

_____

_____

Allergies:

Please list all allergies you have:

Medication Allergies:	Food Allergies:	Environmental Allergies:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Medical History:

Please check any conditions that are prevalent in your immediate family:

☐ Asthma	☐ Diabetes	☐ Heart Attack	☐ Mental Illness
☐ Breast Cancer	☐ Gynecologic Cancer	☐ Interstitial Cystitis	☐ Stroke
☐ Colon Cancer			

Reproductive History:

Are you sexually active: Y N

Decreased erection?	☐ Yes	☐ No
Decreased sensation?	☐ Yes	☐ No
Loss of Libido?	☐ Yes	☐ No
Do you take meds for ED?	☐ Yes	☐ No

Last Prostate exam _____ ☐ Normal ☐ Abnormal Details: _____

Date bone density: _____ Where was it performed: _____

☐ Normal ☐ Abnormal Details: _____

Social History

Please check all that apply to you:

Alcohol	Cigarettes	Illicit Drugs
☐ Currently Use	☐ Currently Use	☐ Currently Use
☐ Never Use	☐ Never Use	☐ Never Use
☐ Previously Used	☐ Previously Used	☐ Previously Used

Martial Status:

☐ Married	☐ Single	☐ Widowed	☐ Divorced