Patient Name:_____
Date:_____

New Patient Past Medical History Form

APEX MEN'S HEALTH CLINIC

Medications (Bring list if needed)

Name	Dose (strength, frequency)

Allergies:_____

Past surgical history... (please list operation name and date)

_____

_____

Have you ever been diagnosed with any of the following...

Cardiac	YES	NO
Heart attack	☐	☐
Congestive heart failure	☐	☐
High blood pressure	☐	☐
High Cholesterol	☐	☐
Chest Pain	☐	☐

Pulmonary		
COPD	☐	☐
Asthma	☐	☐
Shortness of Breath	☐	☐
Pulmonary Embolism	☐	☐
Sleep Apnea	☐	☐

Psychiatric		
Depression	☐	☐
Anxiety	☐	☐
Bipolar	☐	☐

Endocrine	YES	NO
Diabetes	☐	☐
Thyroid problems	☐	☐
Frequent urination	☐	☐
Sensitivity to Heat or Cold	☐	☐

Genitourinary		
Painful Urination	☐	☐
Erectile Dysfunction	☐	☐
Frequent night time urination	☐	☐
Kidney Disease	☐	☐
Prostate disease	☐	☐

Neurological		
Epilepsy	☐	☐
Stroke	☐	☐
Traumatic brain injury	☐	☐
Concussion	☐	☐
Headaches	☐	☐
Dizziness	☐	☐

Musculoskeletal	YES	NO
Back pain	☐	☐
Joint pain	☐	☐
Arthritis	☐	☐
Blood Clots	☐	☐

Gastrointestinal		
Colitis	☐	☐
Crohns	☐	☐
Chronic diarrhea	☐	☐
Chronic constipation	☐	☐
Hepatitis	☐	☐
Acid Reflux	☐	☐

Chronic Disease		
Tuberculosis	☐	☐
HIV / Aids	☐	☐
MRSA	☐	☐
Cancer	☐	☐

Smoking or Vaping History:

Current:____ Former:____ Never:____

Alcohol History:

How often do you have a drink:_____
How many drinks on average:_____
Do you ever drink more than 6 on one occasion: Yes____ No____

Drug History:

Current:____ Former:____ Never:____
Type:_____

Exercise History:

Cardio:____ Lifting:____ Both:____
Days per week:_____
Average number of minutes:____

Diet History:

Poor:____ OK:____ Good:____

Sleep History:

Hours per Night:_____
Wake Feeling Rested:_____
Do you snore:_____
Do you stop breathing in your sleep:_____
Have you ever had a sleep study:____
Are you treated for sleep apnea:_____

Family Medical History:

_____
_____
_____
_____

Testosterone Therapy History:

Have you ever been tested :_____
When:_____
Initial Testosterone level:_____
How long have you been on therapy:_____