MALE MEDICAL QUESTIONNAIRE

This questionnaire must be completed & received prior to your initial consultation with Dr. Silber.

Date: _____

Name: _____
Last Name First Name Nickname

Date of Birth: _____ Height: _____ Weight:_____
mm/dd/yyyy feet/inches pounds

How long have you been together with current partner_____? How long have you been married _____?
How long have you been trying to conceive _____?

Have you ever fathered children?_____ If yes, please list dates, outcomes and current or previous partner:
_____

List dates and results of semen analyses: _____

List dates and results of hormone testing: _____

ALLERGIES:

Are you allergic to any medications (including any tape, iodine, latex, etc) Y ☐ N ☐ If yes:
Medication name: _____ Type of Reaction: _____
Medication name: _____ Type of Reaction: _____

Are you allergic to any food? No ☐ Yes ☐
If yes:
Food name: _____ Type of Reaction: _____
Food name: _____ Type of Reaction: _____

Please list any other allergies:_____

SURGICAL HISTORY:

Have you had any previous surgeries? No ☐ Yes ☐
If yes:
Date of operation Reason, type, & outcome of operation
_____
_____

CURRENT MEDICATIONS: (include all prescriptions, vitamins, supplements, over the counter medications)

Medication Name Dose Frequency
_____
_____
_____
_____

Are you on Oxygen or CPAP? Y ☐ N ☐
Are you taking Testosterone? Y ☐ N ☐ If yes, what kind and for how long? _____

MEDICAL DATA CONTINUED

Please fill out completely (do not write "see records"), if a question is not applicable, please indicate N/A

Date:_____

Name: _____ Date of Birth:_____
Legal Last Name Legal First Name mm/dd/yyyy

SOCIAL HISTORY:

Do you smoke cigars/cigarettes? Y ☐ N ☐ If yes, how much per day/how many yrs_____
Do you smoke marijuana Y ☐ N ☐ If yes, how often, how many yrs_____
Do you use chewing tobacco Y ☐ N ☐ If yes, how often, how many yrs_____
Do you use illicit drugs? Y ☐ N ☐ If yes, what drug, how often, how much_____
Do you drink alcohol? Y ☐ N ☐ If yes, how much per day/how many yrs_____
If you ever smoked in the past, when did you quit?_____

FAMILY MEDICAL HISTORY:

(relationship to you)

Cancer	Y ☐ N ☐	Type:_____
High Blood Pressure	Y ☐ N ☐	_____
Heart Problems	Y ☐ N ☐	_____
Hepatitis	Y ☐ N ☐	_____
Clotting Problem	Y ☐ N ☐	_____
Bleeding Problem	Y ☐ N ☐	_____
Diabetes	Y ☐ N ☐	_____
Seizures/epilepsy	Y ☐ N ☐	_____
Asthma	Y ☐ N ☐	_____
High Cholesterol	Y ☐ N ☐	_____

MEDICAL DATA CONTINUED

Please fill out completely (do not write "see records"), if a question is not applicable, please indicate N/A

Date:_____

Name: _____ Date of Birth:_____

Legal Last Name Legal First Name mm/dd/yyyy

PERSONAL MEDICAL HISTORY:

Have you ever been diagnosed with or are you currently having problems with any of the following?

Cardiac (heart/circulation) Please circle Y for yes or N for no

Congestive heart failure. Y ☐ N ☐
Heart attack. Y ☐ N ☐
Irregular heartbeat. Y ☐ N ☐
High blood pressure. Y ☐ N ☐
Pacemaker. Y ☐ N ☐
Chest pain Y ☐ N ☐
Heart valve problems. Y ☐ N ☐
Palpitations. Y ☐ N ☐
Leg swelling/edema Y ☐ N ☐
Heart murmur. Y ☐ N ☐
Tingling/numbness in feet. Y ☐ N ☐
Leg pain when walking Y ☐ N ☐

Pulmonary/ENT

Shortness of breath Y ☐ N ☐
Asthma Y ☐ N ☐
Recurrent/chronic cough Y ☐ N ☐
Wheezing Y ☐ N ☐
Difficulty hearing Y ☐ N ☐
Bloody cough Y ☐ N ☐
Emphysema/COPD Y ☐ N ☐
Hoarseness Y ☐ N ☐
Chronic sinus infection Y ☐ N ☐
Pulmonary embolism/Clot Y ☐ N ☐
Recurrent bronchitis Y ☐ N ☐
Chronic sore throat Y ☐ N ☐

Ocular

Decreased vision Y ☐ N ☐
Double vision Y ☐ N ☐
Macular degeneration Y ☐ N ☐
Diabetic retinopathy Y ☐ N ☐
Blurry vision Y ☐ N ☐
Cataracts Y ☐ N ☐

Digestive

Heart burn Y ☐ N ☐
Acid reflux disease Y ☐ N ☐
Cirrhosis Y ☐ N ☐
Ulcers Y ☐ N ☐
Pancreatitis Y ☐ N ☐
Crohn's/other colitis Y ☐ N ☐
Abdominal pain Y ☐ N ☐
Diverticulitis Y ☐ N ☐
Irritable bowel syndrome Y ☐ N ☐
Nausea/vomiting Y ☐ N ☐
Loss of appetite Y ☐ N ☐
Rectal bleeding Y ☐ N ☐
Weight Loss surgery Y ☐ N ☐ If yes, what kind and when?_____

Breast

Mass/lump/abn_enlargement Y ☐ N ☐
Aspiration/biopsy Y ☐ N ☐
Fibrocystic breast disease Y ☐ N ☐

Kidney

Kidney failure Y ☐ N ☐
Dialysis Y ☐ N ☐
Kidney/ureteral stones Y ☐ N ☐

Endocrine (hormone)

Thyroid problems Y ☐ N ☐
High/low blood sugar Y ☐ N ☐
Diabetes Y ☐ N ☐
Excessive thirst Y ☐ N ☐
Lupus Y ☐ N ☐
Low testosterone (male) Y ☐ N ☐

Hematologic (blood)

Anemia Y ☐ N ☐
Leukemia Y ☐ N ☐
Clotting problem Y ☐ N ☐
Bleeding problem Y ☐ N ☐
Other_____ Y ☐ N ☐

Infectious disease

Hepatitis A, B, or C Y ☐ N ☐
Aids/HIV Y ☐ N ☐
Tuberculosis Y ☐ N ☐
MRSA infection Y ☐ N ☐
C-Diff. Y ☐ N ☐
Other_____ Y ☐ N ☐

Musculoskeletal

Chronic back problems Y ☐ N ☐ | Chronic neck problems Y ☐ N ☐ | Fibromyalgia Y ☐ N ☐
Osteoarthritis Y ☐ N ☐ | Rheumatoid arthritis Y ☐ N ☐ | Osteoporosis/Osteopenia Y ☐ N ☐
Nontraumatic fractures Y ☐ N ☐ | Joint pain Y ☐ N ☐. If yes, where?_____

Skin

Psoriasis Y ☐ N ☐ | Eczema/rash Y ☐ N ☐ | Changing moles Y ☐ N ☐

MEDICAL DATA CONTINUED

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Neurologic

Seizures Y ☐ N ☐ | Stroke/TIA. Y ☐ N ☐ | Headaches Y ☐ N ☐
Multiple sclerosis Y ☐ N ☐ | Parkinson's. Y ☐ N ☐ | Numbness Y ☐ N ☐
Loss of strength Y ☐ N ☐ | Dizziness/Vertigo Y ☐ N ☐ | Fainting/near fainting Y ☐ N ☐

Genitourinary (Male)

Prostatitis Y ☐ N ☐ | BPH (prostate swelling) Y ☐ N ☐ | Urinary frequency Y ☐ N ☐
Slowing of urinary system Y ☐ N ☐ | Urinary tract infections Y ☐ N ☐ | Sexual dysfunction Y ☐ N ☐

Genitourinary (Female)

Hot flashes Y ☐ N ☐ | Vaginal dryness Y ☐ N ☐ | Urinary frequency Y ☐ N ☐
Urinary tract infections Y ☐ N ☐ | Sexual dysfunction Y ☐ N ☐

Psychologic

Depression/Bipolar Y ☐ N ☐ | Anxiety Nervousness Y ☐ N ☐
ADD/ADHD. Y ☐ N ☐

Cancer Y ☐ N ☐

Type: _____
First Diagnosed: _____
Treatment: _____

Do you have any other health conditions not listed? Y ☐ N ☐. _____