AUSTIN CENTER FOR
MEN'S HEALTH
A division of Austin Fertility & Reproductive Medicine

New Patient Questionnaire

Name: _____ Age: _____

Who referred you/how did you hear about us?

Dr. _____ or
Internet _____ or
Friend/Family _____ or

Chief Complaint:
What is the main concern that you are being seen for today?

History of Present Illness:
How long have you had this problem?

How severe is this problem?

Have you ever been treated for this problem? If so, what did you try and how well did it work?

Does anything make it better or worse?

Are there any associated symptoms that go along with this problem?

Are you currently on or have you ever been on testosterone, body building supplements or steroids? If yes, what kind?

Past Medical History:
What medical problems do you have? (ex: high blood pressure, diabetes, etc)

Past Surgical History:
List all of the surgeries that you have ever had.

Medications:
List any medications including prescription, over the counter, herbs, and supplements that you take (with doses if you know them).

Allergies:
List any medications that you are allergic to and what kind of reaction you had to them.

Social History:
Are you married? Yes / No

Spouse/Partner's full name: _____

Do you smoke? Yes / No

If so how many cigarettes per day and how many years have you been smoking? _____

Do you drink alcohol? Yes / No

If so how many drinks do you have per day or per week? _____

Do you use any illicit drugs? Yes / No
If so, what kind and how often? _____

What is your occupation? _____

Family History:
Do any medical problems (such as cancer) run in the family? Yes / No
If yes, what are they?

Review of Systems:

General:
Have you had any fevers, change in weight, or weakness?

Dermatologic:
Have you had any change in skin, hair or nails?

Pulmonary:
Have you had any cough, wheezing, or difficulty breathing?

Endocrine:
Have you had any heat or cold intolerance or any excess hair growth?

Cardiovascular:
Have you had any chest pain, feeling of your heart skipping beats, or swelling in your legs?

Neurologic:
Have you had any seizures, tremors, or numbness?

Psychologic:
Have you had any depression, anxiety, or lack of interest in doing things that you used to enjoy?

Hematologic:
Do you bruise or bleed easily? Have you been diagnosed with anemia?

Gastrointestinal:
Do you have nausea, diarrhea, or constipation?

Genitourinary:
Do you have blood that you can see in your urine, difficulty urinating, or burning when you urinate?

Patient's signature_____ Date _____