Patient Intake Form For Men

Please complete this form thoroughly, and use extra pages if needed.
For “occupation”, if you are self-employed, please detail your activity so that I can understand what occupation may suggest about your health. Is it sedentary, primarily administrative in nature, or are there any occupational current or prior hazards that might affect your health? Please describe.
Please send copies of recent labs.

Name:
Date of Birth:
Address:
Phone Number:
Ontario Health Card Number:
Occupation:
If you are self-employed, please detail your activity so that I can understand what occupation may suggest about your health. Is it sedentary, primarily administrative in nature, or are there any occupational current or prior hazards that might affect your health? Please describe.

Relationship status:
Height, Weight:
Waist measurement:
Last blood pressure if known:
Primary Care Provider:
Other Health Care Providers:
Allergies:

What are your current health concerns? Please list in priority, note how long you have had these health concerns, what treatments you have tried for these concerns, and the results of the treatments? If you have consulted other healthcare providers for these concerns please include the recommendations and outcome of any treatments advised.

Please note what treatment(s) you are interested in.

Please note your current medical diagnosis, or any current health concerns that you are seeking investigation for.

Please list any current medications including supplements.

Please describe your current diet.

Please describe your digestive health, any reflux, diarrhea, constipation.

Please describe your exercise patterns.

Please describe your sleep and whether you have difficulty falling asleep, staying asleep, or waking up rested.

Please note your past medical history.

Please describe your family history, include all cancers, cardiovascular disease, blood pressure or cholesterol problems.

Do you have any thoughts about biologically fathering a child in your future?

Please note any questions you have about BHRT.

Are you up to date on all recommended cancer screenings? Please be advised that NP Melissa does not provide ongoing primary care and that it Is essential for you to remain up to date on recommended screenings, and to promptly report to Melissa any new or concerning symptoms.

Please complete this questionnaire.
Men's age-related symptoms rating score

Please note each of the 17 symptoms on a scale of 1-5
1 none
2 mild
3 moderate
4 severe
5 extremely severe

1. Decline in your feeling of general well-being
2. Joint pain and muscle ache
3. Excessive sweating
4. Sleep problems (difficulty falling asleep, staying asleep, sleeping through the night, waking up early and tired, poor sleep or sleeplessness)
5. Increased need for sleep, often feeling tired
6. Irritability
7. Nervousness
8. Anxiety
9. Physical exhaustion, lacking vitality
10. Decrease in muscle strength
11. Depressed mood
12. Feeling that you have passed your peak
13. Feeling burnt out
14. Decrease in beard growth
15. Decrease in ability/frequency to perform sexually
16. Decrease in the number or quality of morning erections
17. Decrease in sexual desire/libido

Do you have any other major symptoms? If yes, please describe.