Cunningham Clinic

Getting Started Health Assessment- Male

Name:_____ Date:_____

Phone Number:_____ Email:_____

DOB:_____ Height:_____ Weight:_____ Address:_____

Allergies if any:

_____

_____

Surgical history if any:

_____

_____

Supplements/Medications currently taking and doses:

_____

_____

_____

How many grams of protein do you consume daily?:

_____

Symptom Review: Please check the symptoms that you're experiencing	Not applicable	Moderate	Severe
Physical Exhaustion (fatigue, lack of energy, stamina or motivation)	◯	◯	◯
Sleep Problems (difficulty falling asleep or sleeping through the night)	◯	◯	◯
Irritability (mood swings, feeling aggressive, angers easily)	◯	◯	◯
Anxiety (feeling overwhelmed, feeling panicky, or feeling nervous)	◯	◯	◯
Decline in drive or interest (loss of "zest for life" feeling down or sad)	◯	◯	◯
Joint and muscular symptoms (joint pain, muscle weakness, poor recovery after exercise)	◯	◯	◯
Difficulties with memory (concentration, finding the right word, or retaining information)	◯	◯	◯
Sexual Desire or Performance (reduced or diminished)	◯	◯	◯
Erectile changes (weaker erections, loss of morning erections)	◯	◯	◯
Sweating (night sweats or increased episodes of sweating)	◯	◯	◯
Ejaculations (infrequent or absent)	◯	◯	◯
Hair Loss, Thinning or change in texture of hair	◯	◯	◯
Feeling cold all the time, having cold hands or feet	◯	◯	◯
Headaches or migraines (increase in frequency or intensity)	◯	◯	◯
Bladder Problems (difficulty in urinating, increased need to urinate, incontinence)	◯	◯	◯
Weight (difficulty losing weight despite diet/exercise)	◯	◯	◯

Patient Questions

Date of last Colonoscopy (was it normal or abnormal?):

_____

Are you on a 5-alpha reductase inhibitor? ◯Yes ◯No

Are you on a PDE-5 Inhibitor (Cialis, Viagra, Etc.)? ◯Yes ◯No

Are you on any other testosterone boosting medication (Clomid, HCG, etc.)? ◯Yes ◯No

Date of last Physical (was it normal or abnormal?):

_____

Are you currently seeing a Urologist? ◯Yes ◯No

If you answered yes, indicate why and if you have been cleared to start Hormone Replacement Therapy:

_____

_____

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Are you currently utilizing BHRT or HRT? ◯ Yes ◯ No

If you answered yes, what type of hormones and list dose or hormones:

_____

Patient Questions	Yes	No
Do you smoke?	◯	◯
Are you currently on oral nitrates?	◯	◯
Are you taking a statin?	◯	◯

Medical History:

Fertility:

◯ Want to Maintain Fertility
◯ Do Not Need to Maintain Fertility (my family is complete)

Cardiovascular Conditions:

◯ Heart Attack or Stroke (within last 6 months)
◯ Hyperlipidemia
◯ Atrial Fibrillation
◯ DVT or Blood Clot (within last 6 months)
◯ Obstructive Sleep Apnea
◯ Hypertension
◯ Tachycardia
◯ Patient Takes Anticoagulant Medication

Cancer:

◯ Breast Cancer
◯ Polycythemia Vera (PV)
◯ Meningioma
◯ Active Prostate Cancer or History of Prostate Cancer
◯ Thyroid Cancer or History of Thyroid Cancer
◯ Other Cancers _____ _____ _____

Neurological Conditions:

◯ Epilepsy or Seizure Disorder
◯ Depression/Anxiety

Endocrine and Metabolic:

◯ Hyperthyroid
◯ Diabetes Type 2 or Insulin Resistance
◯ Hypothyroid
◯ Multiple Endocrine Neoplasia Type-2

Autoimmune Conditions:

◯ Diabetes Type 1
◯ Hashimoto's Thyroiditis
◯ Graves' Disease
◯ Ulcerative Colitis
◯ Multiple Sclerosis
◯ Systemic Lupus (Erthematosus)
◯ Psoriasis
◯ Rheumatoid Arthritis
◯ IBS (Irritable Bowel Syndrome)
◯ Crohn's Disease
◯ Positive ANA

Organ Specific Conditions:

◯ Liver Disease or History of Liver Disease
◯ Hepatitis
◯ Hemochromatosis
◯ Kidney Disease or History of Kidney Disease
◯ LAM (Lymphangioleimyomatosis)
◯ HIV
◯ Pancreatitis or History of Pancreatitis
◯ History of or Gall Bladder Disease
◯ Osteoporosis or Osteopenia
◯ Prostate Enlargement (BPH)

Anything else you would like to discuss with your provider:

_____

_____

_____