MALE PATIENT QUESTIONNAIRE AND HISTORY FORM

470.655.6574
gentlegiantcarellc@gmail.com
GentleGiantCareLLC.com
600 Peachtree Parkway, Ste 104
Cumming GA, 30041

Name:_____ Today's Date:_____
(Last) (First) (Middle)

Date of Birth:____/____/_____ Age:_____ Weight:_____ Occupation:_____

Home Address:_____

City:_____ State:_____ Zip: _____

Home Phone:_____-_____-_____ Cell Phone:_____-_____-_____ Work:_____-_____-_____

E-Mail Address:_____ May we contact you via E-Mail? ☐YES ☐NO

In Case of Emergency Contact:_____ Relationship:_____

Home Phone:_____-_____-_____ Cell Phone:_____-_____-_____ Work:_____-_____-_____

Primary Care Physician's Name:_____ Phone:_____-_____-_____

Address:_____
(Street Address) (City) (State) (Zip)

Marital Status (Check One): ☐Married ☐Divorced ☐Widow ☐Living with Partner ☐Single

In the event we cannot contact you by the mean's you've provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Spouse's Name:_____ Relationship:_____

Home Phone:_____-_____-_____ Cell Phone:_____-_____-_____

Social: (Check all that Apply)

☐ I am sexually active.
☐ I want to be sexually active.
☐ I have completed my family.
☐ I have used steroids in the past for athletic purposes.

Habits: (Check all that Apply)

☐ I use_____caffeine per day.
☐ I smoke_____ cigarettes or cigars per day.
☐ I drink_____alcoholic beverages per day.
☐ I drink more than 10 alcoholic beverages per week.

MALE PATIENT MEDICAL HISTORY FORM

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Any known drug allergies:_____

Have you ever had any issues with anesthesia? ☐ Yes ☐ No

If yes please explain:_____

Medications Currently Taking:_____

Current Hormone Replacement Therapy:_____

Past Hormone Replacement Therapy:_____

Nutritional/Vitamin Supplements:_____

Surgeries, list all and when:_____

Other Pertinent Information:_____

MEDICAL ILLNESSES:

☐ High blood pressure. ( ) High cholesterol.
☐ Heart Disease.
☐ Stroke and/or heart attack.
☐ Blood clot and/or a pulmonary emboli.
☐ Hemochromatosis.
☐ Depression/anxiety.
☐ Psychiatric Disorder.
☐ Cancer (Type):_____
Year:_____

☐ Testicular or prostate cancer.
☐ Elevated PSA.
☐ Prostate enlargement.
☐ Trouble passing urine or take Flomax or Avodart.
☐ Chronic liver disease (hepatitis, fatty liver, cirrhosis).
☐ Diabetes.
☐ Thyroid disease.
☐ Arthritis.

I understand that if I begin testosterone replacement with any testosterone treatment, including testosterone pellets, that I will produce less testosterone from my testicles and if I stop replacement, I may experience a temporary decrease in my testosterone production. Testosterone Pellets should be completely out of your system in 12 months.

By beginning treatment, I accept all the risks of therapy stated herein and future risks that might be reported. I understand that higher than normal physiologic levels may be reached to create the necessary hormonal balance.

_____ _____ Date:_____
Print Name Signature