Note: this document is a form that you can fill out. Once filled out you can save it to your PC, then email it to admin@austin3dhealth.com. Please include your name in the filename when you save it to your PC.

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512-328-4041 Office
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PERSONAL INFORMATION

NAME_____ DATE_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

PHONE_____ e-Mail Addr:_____ DATE OF BIRTH_____

MARITAL STATUS_____ AGE_____ NUMBER OF CHILDREN_____

OCCUPATION_____ EMPLOYER_____

ADDRESS_____CITY/ZIP_____TELEPHONE_____

NAME OF SPOUSE_____ SPOUSE'S OCCUPATION_____

EMPLOYER_____

ADDRESS_____CITY/ZIP_____TELEPHONE_____

EMERGENCY NOTIFICATION

NAME _____

ADDRESS_____CITY/ZIP_____TELEPHONE_____

REFERRED BY_____

MALE HEALTH HISTORY QUESTIONNAIRE

Weight: _____ Height: _____ Occupation: _____

What is the reason for this visit?

_____

_____

Do you have any pain at this time?

_____

List medications you are currently taking:

_____

_____

Any known drug allergies? _____

Do you or have you used hormone replacement therapy? Yes☐ No☐

If so, what? _____ When?_____ Dosage? _____

List natural supplements, herbs, remedies, including athletic performance supplements you are currently taking:

_____

_____

List your history of surgeries/hospitalizations (e.g., knee replacement, vasectomy)

_____

List any health issues (e.g., diabetes)

_____

_____

What was the date of your last physical exam? _____

LIFESTYLE INDICATORS < = less than > = greater than

1. Do you use any of the following? (circle responses)

Alcohol None ☐	<2 drinks/day ☐	>2 drinks/day ☐
Coffee None ☐	<2 cups/day ☐	>2 cups/day ☐
Soda None ☐	<2 cans/day ☐	>2 cans/day ☐
Sweets/refined carbs	<twice/day ☐	>twice/day ☐

2. Do you smoke cigarettes/cigars or use nicotine gum? Yes No How much/often? _____

3. How would you rate your stress level? (1=Low, 10=Extreme) 1 2 3 4 5 6 7 8 9 10

4. How would you rate your stress handling? (1=Poor, 10=Excellent) 1 2 3 4 5 6 7 8 9 10

1. Have you had a vasectomy? Yes ☐ No ☐ When? _____

2. Have you had a reverse vasectomy? Yes No When? _____

3. Have you experienced symptoms related to the vasectomy? Yes ☐ No ☐

Explain: _____

_____

4. Do you have a history of prostate problems? Yes ☐ No ☐

Explain: _____

_____

Date of last Prostate Exam _____

Most recent PSA results _____ Date _____

SLEEP HABITS

1. How do you sleep? Well ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Insomnia ☐

How long has this been happening? _____

2. How many hours do you sleep a night on average? _____

3. Do night sweats wake you up? Yes No How often? _____

4. Do you wake up tired? Yes No How long has this been happening? _____

5. Is your room completely dark when you sleep at night? *(no night light, street lamp, TV, etc.)* Yes ☐ No ☐

6. Do you get at least 30 minutes of outside daylight time, several days each week? Yes ☐ No ☐

SIGNS & SYMPTOMS	MILD	MODERATE	SEVERE	ADDITIONAL COMMENTS
Low mood / Depression	☐	☐	☐	
Irritability	☐	☑	☐	
Anxiety	☐	☑	☐	
Anger / Aggression	☐	☑	☐	
Discouragement / Pessimism	☐	☑	☐	
Decreased interest in activities/relationships	☐	☑	☐	
Decreased initiative / motivation / drive	☐	☑	☐	
Decreased productivity at work	☐	☑	☐	
Concentration problems	☐	☑	☐	
Memory problems	☐	☑	☐	
Foggy thinking	☐	☑	☐	
Increased fatigue	☐	☑	☐	
Decrease in strength / stamina	☐	☑	☐	
Decrease in athletic performance	☐	☐	☐	
Decreased lean muscle mass	☐	☐	☐	
Muscle soreness / weakness	☐	☐	☐	
Body / joint aches	☐	☐	☐	
Weight loss	☐	☐	☐	
Weight gain	☐	☐	☐	
Increased fat on hips / breasts / thighs	☐	☐	☐	
Low blood sugar / hypoglycemia	☐	☐	☐	
Sweet cravings (carbs/chocolate)	☐	☐	☐	
Caffeine/Stimulant cravings	☐	☐	☐	
Salt cravings	☐	☐	☐	
Constant hunger	☐	☐	☐	
Elevated cholesterol	☐	☐	☐	
Elevated blood pressure	☐	☑	☐	
Digestive problems	☐	☐	☐	
Head hair loss	☐	☐	☐	
Body hair loss	☐	☐	☐	
Dry skin / thinning skin	☐	☐	☐	
Decreased spontaneous	☐	☐	☐	
morning erections	☐	☐	☐	
Lowered Libido	☐	☐	☐	
Erectile Dysfunction (ED)	☐	☐	☐	
Pain with ejaculation	☐	☐	☐	
Frequent need to urinate	☐	☐	☐	
Urination is delayed/strained/incomplete	☐	☐	☐	
Pain with urination	☐	☐	☐	
Blood in the urine	☐	☐	☐	
Bone loss/osteoporosis	☐	☐	☐	
Other	☐	☐	☐	

Any other symptoms? _____

Please circle symptoms that apply:

Chest:	Pain ☐	Tightness ☐	Palpitations ☐	Reflux ☐	
Headaches:	Sharp ☐	Dull ☐	Migraines ☐	Nausea ☐	Vomiting ☐
Ears:	Ringing ☐	Drainage ☐	Itch ☐	Dizzy ☐	Ache ☐
Eyes:	Blurry ☐	Floaters ☐	Dry ☐	Puffy ☐	Twitch ☐ Circles ☐
Sinus:	Post-Nasal-Drip ☐	Sneezing ☐	Sore Throat ☐	Asthma ☐	Cough (dry / mucus) ☐
Allergies:	Foods ☐	Environmental ☐			
Fever:	Day ☐	Late afternoon ☐	Night ☐	Low-grade	Are you always: Hot or Cold

For Practitioner's Use Only

Blood Pressure: _____ /_____

Pulse: _____

Tongue: _____

Diet:

Breakfast_____

Lunch _____

Dinner _____

