T Off Medical and Surgical History Form

NAME: _____ DATE: _____ DOB: _____ AGE: _____

What is your main purpose for coming in to the office today?

❑ Routine Physical ❑ Medical Management ❑ Sick visit ❑ Allergies ❑ Testosterone therapy ❑ Weight loss ❑ Preventive

- When did your chief complaint start and where is it at? (if applicable)_____
- What is the severity of your pain? (mild, moderate, severe) Rank your pain (0=no pain/10= Sever pain) _____
- Describe the pain or problem? (dull, sharp, achy, constant, intermittent)_____
- What makes the pain better and/or worse? Ex. Medications?"_____
- Does your pain radiate anywhere? _____
- Is it improving/worsening/staying the same? Was there a trigger? What do you think is causing your pain?"_____ _____
- Any additional concerns? _____

Please check the boxes if you have any of the following system's.

General:
❑Fatigue or loss of energy
❑Unintentional weight loss
❑Fever
❑Snoring
❑Daytime sleepiness
❑Waking up unrested
❑Falling asleep while watching TV/reading

Eyes:
❑Blurred or double vision
❑Itchy/watery eyes
❑Vision changes
❑Eye redness

Ears, Nose, Throat and Mouth:
❑Hearing loss
❑Earache
❑Nose bleeds
❑Ear discharge

Neurological:
❑Headache
❑Dizziness
❑Fainting
❑Seizure
❑Tingling
❑Numbness

Allergies:
❑Nasal itching or stuffiness
❑Allergies
❑Sinus problems
❑Sore throat
❑Rashes

Cardiac:
❑Chest pain/pressure/tightness
❑Palpitations
❑Exercise Intolerance
❑Pain walking
❑Lightheaded
❑Varicose veins

Hematologic/lymphatic:
❑Easy bruising
❑Bleeding disorder
❑Clotting disorder
❑Swollen glands

Lungs:
❑Wheezing
❑Shortness of breath at rest or with exertion
❑Chronic cough
❑Asthma

Digestive:
❑Difficulty swallowing
❑Abdominal pain
❑Heartburn
❑Nausea/vomiting
❑Constipation
❑Diarrhea
❑Bloody stool
❑Hemorrhoids

Musculoskeletal:
❑Muscle weakness
❑Pain in muscles
❑ Back pain
❑Joint pain/redness
❑Loss of muscle

Genitourinary:
❑Urinary pattern change
❑Change in testicle size
❑Blood in urine
❑Problems urinating
❑Testicular mass
❑Erectile Dysfunction
❑History of trauma to testicles

Skin:
❑Dry
❑Itchy
❑Rashes
❑Hives
❑Lumps
❑Mole changes
❑Loss of hair

Psychiatric:
❑Depression/irritability
❑Feeling overwhelmed
❑Feeling hopeless
❑Anxious/nervous
❑Confused
❑Stressed
❑Decrease motivation, confidence or initiative

Endocrine:
❑Heat and cold intolerance
❑Weight changes
❑Decreased libido
❑Breast enlargement or tenderness
❑Loss of erectile strength or loss of early morning erections

Other:

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Do you have a primary care doctor? ❑YES ❑NO Who is your doctor? _____

Have you been feeling? ❑Fatigue ❑ Decreased sexual stamina/desire ❑ Muscle weakness and loss ❑ Moodiness ❑ History of low testosterone ❑ Problem with erections ❑ Lack of motivation ❑ Sleep disturbances ❑ Increased weight gain ❑ increase in abdominal fat ❑ Hair loss ❑ Gynecomastia ❑ Decreased semen volume ❑ Decrease in bone mass ❑ Decreased spontaneous erection ❑Noticeable decrease in testicular size

Medications and Allergies

List your current medications: ❑NONE_____

List your medication allergies: ❑NONE _____

Medical History

Have you ever been diagnosed with? ❑ **NO to all the below diseases**

Diabetes	NO	YES	YEAR:_____	Low Testosterone	NO	YES	YEAR:_____
High Blood Pressure	NO	YES	YEAR:_____	Prostate disease	NO	YES	YEAR:_____
High cholesterol	NO	YES	YEAR:_____	Abnormal prostate exam	NO	YES	YEAR:_____
Heart disease	NO	YES	YEAR:_____	Abnormal PSA	NO	YES	YEAR:_____
Lung disease	NO	YES	YEAR:_____	Damage to the testes	NO	YES	YEAR:_____
Liver disease	NO	YES	YEAR:_____	Testicular cancer	NO	YES	YEAR:_____
Gastrointestinal disease	NO	YES	YEAR:_____	Erectile dysfunction	NO	YES	YEAR:_____
Allergies	NO	YES	YEAR:_____	Cottonseed oil Allergy	NO	YES	YEAR:_____
Asthma	NO	YES	YEAR:_____	Skin problems	NO	YES	YEAR:_____
Sleep apnea	NO	YES	YEAR:_____	Blood disorder	NO	YES	YEAR:_____
Cancer	NO	YES	YEAR:_____	OTHER:_____			
Thyroid disease	NO	YES	YEAR:_____	OTHER:_____			

When was your last rectal exam or prostate exam? Date: _____ ❑ I have never had a prostate exam.

Have you ever had a colonoscopy? YES NO **Have you ever had an upper endoscopy (EGD)** YES NO

Have you ever been hospitalized for anything? _____

Surgical History

What surgeries have you had since birth? _____

Social History

Marital Status: ❑Married ❑Single ❑Divorced ❑Long term relationship

Do you still want to have children? ❑YES ❑NO When do you want children? ❑ <6 months ❑ 6-12 mths ❑ >12 mths

Have you had problems fathering children for > 1 year? ❑YES ❑NO

Have you ever smoked cigarettes? YES NO ❑Current smoker ❑ Former smoker ❑ Current tobacco use

Number of packs per day___ Number of years used ___ ❑ Quit attempts____ ❑ Assistance requested ❑YES ❑NO

Do you use recreation drugs? YES NO What kind and how often? _____

Do you drink alcohol? YES NO _____ # of drinks every ___day___week___month___yearDo you drink caffeine or energy drinks? YES NO _____ # of drinks every ___day___week___month___year

Family History

FATHER: Age_____ Living/Deceased ❑Diabetes ❑High Blood Pressure ❑Stroke ❑Prostate cancer ❑Heart disease ❑Breast cancer ❑Colon cancer ❑Thyroid disease ❑Other Cancer ❑ Other_____

MOTHER: Age_____ Living/Deceased ❑Diabetes ❑High Blood Pressure ❑Stroke ❑Prostate cancer ❑Heart disease ❑Breast cancer ❑Colon cancer ❑Thyroid disease ❑Other Cancer ❑ Other_____

SISTER: Age_____ Living/Deceased ❑Diabetes ❑High Blood Pressure ❑Stroke ❑Prostate cancer ❑Heart disease ❑Breast cancer ❑Colon cancer ❑Thyroid disease ❑Other Cancer ❑ Other_____

BROTHER: Age_____ Living/Deceased ❑Diabetes ❑High Blood Pressure ❑Stroke ❑Prostate cancer ❑Heart disease ❑Breast cancer ❑Colon cancer ❑Thyroid disease ❑Other Cancer ❑ Other_____

MATERNAL GANDFATHER: Age_____ Living/Deceased ❑Diabetes ❑High Blood Pressure ❑Stroke ❑Prostate cancer ❑Heart disease ❑Breast cancer ❑Colon cancer ❑Thyroid disease ❑Other Cancer ❑ Other_____

MATERNAL GRANDMOTHER: Age_____ Living/Deceased ❑Diabetes ❑High Blood Pressure ❑Stroke ❑Prostate cancer ❑Heart disease ❑Breast cancer ❑Colon cancer ❑Thyroid disease ❑Other Cancer ❑ Other_____

PATERNAL GRANDFATHER: Age_____ Living/Deceased ❑Diabetes ❑High Blood Pressure ❑Stroke ❑Prostate cancer ❑Heart disease ❑Breast cancer ❑Colon cancer ❑Thyroid disease ❑Other Cancer ❑ Other_____

PATERNAL GRANDMOTHER: Age_____ Living/Deceased ❑Diabetes ❑High Blood Pressure ❑Stroke ❑Prostate cancer ❑Heart disease ❑Breast cancer ❑Colon cancer ❑Thyroid disease ❑Other Cancer ❑ Other_____

Any additional comments or concerns:

_____

_____

_____

For questions specific to women, please refer to additional form given.

Additional screening tools are available for people who may have:

1. Concussion/Traumatic Brain Injury
2. PTSD or Post Traumatic Stress Disorder
3. Depression
4. Anxiety

_____ _____/_____

Patient Name Date/DOB

Screening Tool for Sleep Apnea

This is a screening test for sleep apnea. If this assessment is positive, then you may benefit from further assessment and a sleep study.

Developed by David White, MD, Harvard Medical School, Boston, MA

1. **Snoring**
   a. Do you snore on most nights (> 3 nights per week)? YES (2) NO (0) _____
   b. Is your snoring loud? Can it be heard through a door or wall YES (2) NO (0) _____

2. **Has it ever been reported to you that you stop breathing or gasp during sleep?**
   Never (0) Occasionally (3) Frequently (5) _____

3. **What is your collar size?**
   Man: Less than 17 inches (0) more than 17 inches (5) _____
   Woman: Less than 16 inches (0) more than 16 inches (5) _____

4. **Do you occasionally fall asleep during the day when:**
   a. You are busy or active? YES (2) NO (0) _____
   b. You are driving or stopped at a light? YES (2) NO (0) _____

5. **Have you had or are you being treated for high blood pressure?** YES (1) NO (0) _____

Score: _____

9 points or more: Refer for sleep study
6-8 points: Gray area, use clinical judgment
5 points or less: Low probability of sleep apnea

_____ _____
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AUA Symptom Score

Circle One Number on Each Line	Not at all	Less than 1/5 Times	Less than Half the Time	About Half the Time	More than Half the Time	Almost Always
Over the past month, how often have you had a sensation of not completely emptying you bladder after urinating?	0	1	2	3	4	5
Over the past month, how often have you had to urinate again within two hours than the prior urination?	0	1	2	3	4	5
Over the past month, how often have you stopped and started again several times during urination?	0	1	2	3	4	5
Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
Over the past month, how often have you had to strain to start urination?	0	1	2	3	4	5
Over the past month, how many times per night did you have to get up to urinate between the time you went to bed until the time you woke up in the morning?	0	1	2	3	4	5
Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5

Add the score for each number above and write the total: _____

Symptom Score: 1-7 Mild 8-19 Moderate 20-35 Severe

_____ _____

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