Welcome to Mantality Health. Through our desire to provide you with the most focused and personalized experience, we would like to understand the primary reason that has brought you to the clinic today.

Please list your overall goals during treatment:

1. _____
2. _____
3. _____

Describe a time when you were performing at your best:

_____

_____

PATIENT INFORMATION:

How did you hear about us?

☐ Referral: _____ ☐ Internet ☐ Radio: _____

General Information:

Date: _____ Birth Date: _____ Age: _____

Name: _____ Email: _____

LAST FIRST MI

Date: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Cell Phone: (____) ____-_____

May we send you a text message reminders regarding appointments? Yes No ☐ ☐

Place of Employment: _____ Phone: (____) ____-_____

Employer Address: _____

City: _____ State: _____ Zip: _____

Primary Doctor: _____ Phone: (____) ____-_____

POLICY HOLDER INFORMATION (*if different than yourself)*:

Name: _____ Relationship: _____

LAST FIRST MI

Date of Birth: _____/_____/_____ Phone: (____) ____-_____

Policy ID #: _____ Group #: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____
LAST FIRST MI
Home Phone: (____) ____-_____ Cell Phone: (____) ____-_____

PATIENT HISTORY

YES NO Have you had any muscle weakness, fatigue or loss of muscle mass?
YES NO Has your interest in sex (libido) declined?
YES NO Do you have spontaneous erections (without medication or other aid)?
YES NO Has your energy or stamina declined?
YES NO Have you lost self-confidence, motivation or initiative?
YES NO Has there been any decline in memory or concentration ability?
YES NO Have you had any sleep disturbance or problems breathing while asleep?
YES NO Do you have mood swings or depression?
YES NO Have you noticed any increase in aggressiveness?
YES NO Do you have any breast tenderness or enlargement?
YES NO Have you lost any hair in the genital or underarm areas?
YES NO Has your need to shave decreased?
YES NO Have you noticed any significant change in the size of your testicles?
YES NO Do you have periodic hot flashes or sweats?
YES NO Have you ever had problems achieving a pregnancy?
YES NO Are you considering having any (or more) children?

FAMILY HISTORY

YES NO Do you have any blood related family members with breast cancer?
YES NO Do you have any blood related family members with prostate cancer?
YES NO Do you have any blood related family members with diabetes?
YES NO Do you have any blood related family members with cardiovascular disease?

SOCIAL HISTORY

YES NO Do you use tobacco? If yes, how many packs per day: _____
YES NO Do you drink alcoholic beverages? If yes, how much and how often: _____

PAST HISTORY

YES NO Have you ever had an abnormal PSA test or prostate exam?
If yes, explain: _____
Do you have or have you ever had:
YES NO Thyroid Disease. Explain: _____
YES NO Diabetes. Explain: _____
YES NO High Blood Pressure. Explain: _____
YES NO Asthma/Lung Disease. Explain: _____
YES NO Acne, Dry or Oily Skin. Explain: _____
YES NO Venereal Disease. Explain: _____
YES NO Do you have any allergies to any medications? If so, list:
_____

Do you currently take any medications? If so, list below:

Medication	Dose	How Often	Reason	Prescribing M.D.

REVIEW OF SYMPTOMS (*please check all that apply):*

Ears, Nose and Throat:
____ Hearing Loss
____ Ringing in Ears
____ Altered Sense of Smell
____ Trouble Swallowing
____ Neck Pain/Stiffness

Lungs:
____ Nonproductive Cough
____ Pain w/ Breathing at Rest
____ Pain w/ Breathing with Exertion
____ Pain wit Inspiration
____ Wheezing
____ Coughing up Blood
____ Short of Breath w/ Exertion

Cardiovascular System:
____ Chest Pain/Pressure at Rest
____ Chest Pain/Pressure with Exertion
____ Heart Palpitations
____ Normal Tolerance to Exercise
____ Pain in Legs when Walking
____ Cold Hands/Feet
____ Fainting
____ Lightheadedness

Hematology (Blood):
____ Anemia
____ Hemochromatosis

Allergic:
____ Hives

Gastrointestinal System:
____ Pain with Swallowing
____ Abdominal Pain
____ Nausea
____ Vomiting

Eyes:
____ Headache
____ Blurry Vision
____ Double Vision
____ Visual Changes.

Genitourinary System:
____ Pain with Urination
____ Urinary Frequency
____ Urinary Infrequency
____ Blood in Urine
____ Trouble Starting Stream
____ Difficulty Stopping Stream
____ Erectile Dysfunction

Neurological System:
____ Headache
____ Loss of Sensation in any Part of Body
____ Weakness of any Extremity
____ Uncontrolled Muscle Movements
____ Dizziness
____ Problems with Walking
____ Speech Disturbance

Musculoskeletal System:
____ Joint Pain (any Joint)
____ Pain in any Muscles
____ Muscle Weakness

General Constitution:
____ Fatigue
____ Night Sweats
____ Weight Loss
____ Weight Gain

Integumentary (Skin) System:
____ Rashes

Psychiatric:
____ Depressed

Endocrine:
____ Goiter
____ Appetite Change
____ Heat or Cold Intolerance

Patient Signature: _____

Date: _____