WeCare Integrative Medicine

MALE PATIENT QUESTIONNAIRE & HISTORY

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

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

Home Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work:_____

In Case of Emergency Contact:_____ Relationship:_____

Home Phone:_____ Cell Phone:_____ Work:_____

Pharmacy Name:_____ Phone:_____

Address:_____

Primary Care Physician's Name:_____ Phone:_____

Address:_____

May we share your clinical information with your PCP/Urologist? ☐ Yes ☐ No

How did you hear about us?

☐ Patient _____ ☐ Event _____

☐ Practitioner _____ ☐ Pharmacy _____

☐ Social Media _____ ☐ TV _____ ☐ TV _____

☐ Web _____ ☐ Signage _____ ☐ Print _____

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.

Name:_____ Relationship:_____

Home Phone:_____ Cell Phone:_____ Work:_____

Social:

( ) 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:

( ) I smoke cigarettes or cigars _____ per day.
( ) I drink alcoholic beverages _____ per week.
( ) I drink more than 10 alcoholic beverages a week.
( ) I use caffeine _____ a day.

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

Print Name	Signature	Today's Date

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