

Male Patient Information

Name: _____ Today's Date: _____
LAST MIDDLE FIRST

Date of Birth: _____ Social Security #: _____

Street address: _____

City: _____ State: _____ Zip: _____

Phone numbers: Home _____ Cell _____

Do you have an email address you can share with us? _____

We would like to stay in contact with you at all times. Please provide us with a summer residence location if you have one: _____

Patient employed by: _____

Business address: _____

Business phone: _____

Marital status: (please circle) Married Divorced Single Widow Living with Sig. Other

Spouse's Name: _____
FIRST LAST

Spouse's date of birth: _____ Social Security #: _____

Spouse employed by: _____ Business phone: _____

In case of emergency, whom should we notify? _____

Phone number(s): _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. In order to control the cost of billing, we request that our charges for office visits be paid at the conclusion of each visit. If this account is assigned to an attorney for collections and/or suit, the prevailing party shall be entitled to reasonable attorney fees and costs of collection. I authorize the release of information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance and any other insurance to: _____ . This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature: _____ Date: _____

SEXUAL HISTORY

1. Age of first sexual contact: _____
2. Are you sexually active? YES NO
3. Do you have a history of Sexually Transmitted Diseases? YES NO
If yes, please list: _____
4. Have you had a sperm count? YES NO
Results: _____
5. Have you had the Mumps? YES NO
Date: _____
6. Have you had Testicular Cancer? YES NO
Date: _____
7. Do you have Prostate Problems? YES NO
If yes, please describe: _____
8. Have you had blood in your urine? YES NO
If yes, when & treatment: _____
9. Have you had any bladder or kidney problems? YES NO
If yes, when & treatment: _____
10. Do you have erectile dysfunction? YES NO
If yes, please describe: _____
11. Do you have:
 - Fatigue? YES NO
 - Decrease of memory? YES NO
 - Decrease of energy level? YES NO
 - Decrease of sexual drive? YES NO
12. Do you suffer from:
 - Anxiety? YES NO
 - Irritability? YES NO
 - Mood swings? YES NO
 - Migraines? YES NO
13. How have you dealt with these symptoms?

14. Do you initiate intercourse? YES NO
15. Is intercourse satisfying? YES NO
16. Do you achieve orgasm? YES NO
17. Do you suffer from premature ejaculation? YES NO
18. How often do you have intercourse?

19. Is your sex drive the same as it was five years ago? YES NO
Describe: _____

20. List any other sexual dysfunctions:

21. Have you experienced weight gain in the last one-two years? YES NO
If yes, please describe: _____

22. Have you lost greater than 10 pounds in less than a month? YES NO
If yes, why? _____

23. Are you HIV positive? YES NO
If yes, when? Describe: _____

24. Have you ever been tested for AIDS? YES NO
Results? _____

25. Have you fathered any children? YES NO
If yes, how many? _____

26. Have you had your Testosterone level taken? YES NO

27. List current medications:

28. Sexual Orientation?

Heterosexual

Homosexual

Bisexual

PAST MEDICAL HISTORY

1. Do you have diabetes? YES NO

2. Do you have/had hypertension? YES NO

3. Do you have heart disease? YES NO

4. Do you have a heart murmur? YES NO

5. Do you have/had kidney disease? YES NO

6. Have you ever been treated for psychiatric problems? YES NO

7. Have you ever had rheumatic fever? YES NO

8. Do you have mitral valve prolapse? YES NO

9. Have you ever had a urinary tract infection? YES NO

10. Have you ever had hepatitis/liver disease? YES NO

11. Have you ever had varicosities/phlebitis? YES NO

12. Do you have any thyroid problems? YES NO

13. Have you had any major accidents? YES NO

14. Have you ever had any blood transfusions? YES NO

15. Do you have asthma/lung disease? YES NO

16. Do you have lupus? YES NO

17. Do you have arthritis? YES NO

18. Do you have any Drug Allergies? YES NO

If yes, please list: _____

19. Please list any surgeries: _____

20. Please list any other operations/hospitalizations (include year & reason):

21. Have you had any anesthesia complications: YES NO

If yes, please list: _____

22. Have you ever been anemic? YES NO

23. Do you have an Internist or Family Doctor? YES NO

Please list name, phone number: _____

24. Have you had your cholesterol checked? YES NO

If yes, date last checked? _____

Was it normal? YES NO

SOCIAL HISTORY

1. Do you smoke cigarettes? YES NO

If yes, number per day? _____ Number of years? _____

2. Do you use street drugs? YES NO

3. Do you drink alcohol? YES NO

If yes, how much per day? _____

TIRPACK GYNECOLOGY

Jill Tirpack, M.D.