Male Patient Form

Last Name:	First:	Middle:
Date of Birth:	Email Address:	
Street Address:		
City:	State:	Zip Code:
Cell Phone:	Home Phone:	Work Phone:
Preferred Method of Communication:		
Marital Status:		
Emergency Contact		
Name:		Relationship:
Cell Phone:	Home Phone:	
Are you Medicare recipient?	☐ NO ☐ YES	
	☐ PART A ☐ PART B ☐ BOTH	
How did you hear about Exuberan?		
☐ Physician ☐ Friend ☐ Health care event	☐ Magazine ☐ Newspaper	☐ TV ☐ Radio
Please circle whatever symptoms may have caused you to seek Bioidentical Hormone Replacement therapy		
Fatigue	Poor exercise tolerance	Decreased sex drive
Decreased mental clarity	Muscle loss	Premature ejaculation
Anxiety	Migraines	Unable to achieve orgasm
Decreased energy level	Memory loss	Erectile dysfunction
Mood Swings	Irritability	Infertility/known low sperm count
Libido	Other:	

Name ______________________

Medical History		
What have you done to manage these symptoms in the past?		
HRT	Patches	Gels
Pills	Herbals	Other
Currently taking:		
Is intercourse satisfying for you? ☐ Yes ☐ No		
How often do you have intercourse?		
☐ Daily ☐ Weekly ☐ Monthly ☐ Bi-monthly ☐ Yearly ☐ Not at all		
Any other sexual problems you are experiencing?		
If yes please list:		
History of Sexually Transmitted Diseases?	☐ Yes ☐ No	
Disorders of prostate	☐ Cancer ☐ Enlarged Prostate ☐ Prostatitis ☐ Prostate	
If yes please describe treatment		
Date of Last PSA exam	☐ Normal ☐ Abnormal	
Date of Last Prostate exam		
Do you have increased urinary frequency?		
Do you have trouble starting urine flow?		
Do you have trouble emptying your bladder?		
Do you have any bladder or kidney problems?		
Describe:		

Past Medical History		
Please check and date any of the following you currently have or have had in the past.		
Diabetes	Heart disease	Kidney disease
High blood pressure	Thyroid disease	Respiratory disease
Stroke/TIA	Liver Disease	Parkinson's disease
Blood clot/ Bleeding problem	Mental health disorder	Other
Cancer - Type and Date		

Name ______________________________

List all Surgeries	Date or Surgery
Have you had a vasectomy ? ☐ Yes ☐ No	

List all Medication you are currently taking including over the counter, herbal, and supplements

Pharmacy Information	
Name:	Address:
Phone number:	Fax number:
Are you currently now or have you ever used any Testosterone or Hormone Therapy? ☐ Yes ☐ No	
Describe:	

Allergies		
Allergies:	Reactions:	
No Known Drug Allergy		
Latex		
Iodine		
Epinephrine		
Other		
Do you smoke? ☐ Yes ☐ No	If yes, How long?	Packs/day
Do you use alcohol? ☐ Yes ☐ No	If yes, How much?	
Do you use recreational drugs? ☐ Yes ☐ No	If yes, Describe:	

Please fax or e-mail your completed forms to exuberan@virtua.org prior to your appointment.

Our confidential fax is 856-762-2732