Solutions Pharmacy

Phone: (423) 894-3222 / Toll Free:(800) 523-1486
Fax: (423) 499-8435 / Toll Free Fax: (877) 890-8435
Hours: M-F: 9am-7pm

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? _____

Patient employed by: _____

Business address: _____

Business phone: _____

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

Spouse's Name: _____
FIRST LAST

In case of emergency, whom should we notify? _____

Phone number(s): _____

Signature: _____ Date: _____

tory of Sexually Transmitted Diseases? ❑ YES ❑ NO 2. Do you have a hi
first: _____ 3. If yes, pleas

Have you had Testicular Cancer? ❑ YES ❑ NO 4.

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

_____

19. Have you ever been tested for AIDS? ❑ YES ❑ NO
Results? _____
20. Have you fathered any children? ❑ YES ❑ NO
If yes, how many? _____
21. Have you had your Testosterone level taken? ❑ YES ❑ NO
List current medications:

_____

_____

_____

22. 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? _____

FAMILY HISTORY

1. Do you have a family history of breast cancer? ❑ YES ❑ NO
   If yes, whom? _____
2. Do you have a family history of colon cancer? ❑ YES ❑ NO
   If yes, whom? _____
3. Do you have a family history of prostate cancer? ❑ YES ❑ NO
   If yes, whom? _____
4. Do you have a family history of osteoporosis? ❑ YES ❑ NO
   If yes, whom? _____
5. Do you have a family history of diabetes? ❑ YES ❑ NO
   If yes, whom? _____
6. Do you have a family history of hypertension? ❑ YES ❑ NO
   If yes, whom? _____
7. Do you have a family history of heart disease? ❑ YES ❑ NO
   If yes, whom? _____
8. Do you have a family history of kidney disease? ❑ YES ❑ NO
   If yes, whom? _____