Caudle Cosmetic Surgery, Wellness, & Aesthetics 189 Corporate Drive #10 Johnson City,TN 37604 Ph: (423) 926-2400

General Male Medical History & Physical Caudle Health

Patient Full Name: _____ Date: ____/____/_____

Your appointment date & time is: _____/_____/_____@_____am pm. Bring any medical records such as scans, labs, X-rays etc.

Patient Information **Bring Insurance Information & Photo ID (driver's license) to Office Visit**

Name:_____

Address:_____City:_____State:_____Zip_____

Phone (_____)_____ Work Phone (_____) _____ Cell Phone (_____)_____

The best time to contact me is:_____ ☐ morning ☐ afternoon ☐ evening at ☐ Home ☐ Work ☐ Cell.

Date of Birth: _____/_____/_____ Social Security Number:_____-_____-_____

If Student, Name of School_____ City/State_____ ☐ FT ☐ PT

Spouse or Parent's Name:_____ Employer_____ Work Phone_____

Person to contact in case of emergency_____ Phone_____

Provide **your email** & you can access your health records online securely:_____

Referring Doctor(first&last name):_____ Phone#:____-____-_____Fax#:____-____-_____

☐ Our Website ☐ Friend ☐ Facebook ☐ Google ☐ Bing ☐ Radio ☐ Billboard ☐ TV

☐ Walk-in ☐ Phone book ☐ Newspaper / Print ☐ Digital Advertising ☐ Different Website _____

Reason for visit: Please include when condition (s) started, is it better or worse now? What tests/ treatments have been done? Any Medications started? If you have pain, please describe below and include Location - Timing (constant, occasional, episodic, minuets/hours, a.m./p.m.) – Quality of pain (ache, sharp, dull, burning, etc.). - What makes it worse/ better (eating, movement, straining, etc.)?:_____

_____

_____

_____

_____

How many children do you have? _____ Have you undergone vasectomy? _____

Do you have any trouble with erectile dysfunction? _____ Low libido? _____

Do you do regular testicular exams? _____ Have you had the following screening tests?

Prostate Exam: _____ Date of last test: _____ PSA: _____ Date of last test: _____

How did you arrive at the decision to start Bio-Identical Hormone replacement?

_____

What are your goals with taking Bio-Identical Hormone replacement therapy?

_____

Please list any questions or concerns you have regarding Bio-Identical Hormone replacement:

_____

The following factors INCREASE the RISK of LOW TESTOSTERONE or HYPOGONADISM.
CHECK the factors that apply to you:

__ low libido (low sex drive) __ decreased morning erections __ loss of body hair

__ gynecomastia (man boobs) __ small testes __ fatigue / lack of energy

__ depression __ reduced muscle strength __ increased obesity

__ Poor lifestyle factors such as poor food choices and lack of adequate exercise contribute to low testosterone.

__ A history of low trauma fracture suggests low bone mineral density. (bone fracture from mild injury)

__ Potentially reversible causes of hypogonadism such as use of any drugs (__ metoclopramide, __ opiates (chronic pain medication), __ DHEA/HCG/Proscar-Propecia(finasteride), __ anabolic steroids, __ acute severe systemic illness, __ chronic systemic illness, __ type II diabetes, __ metabolic syndrome, __ obesity (especially

abdominal obesity). __ COPD / emphysema, __ coronary artery disease, __ chronic renal disease, __ chronic alcoholism, __ chronic opiate addiction, or __ steroid therapy such as prednisone, glucocorticoids

Hypothyroidism: Subclinical or Symptomatic: Do you have these symptoms consistent with low thyroid: ___ weakness, ___ lack of energy, ___ depression, ___ weight gain.

Low Vitamin D Risk Factors: ___ inadequate sunlight, ___ breast feeding, ___ calcium deficiency, ___ phosphate deficiency, ___ dark skinned, ___ Use of frequent: __ antacids __ loop diuretics __corticosteroids __ anticonvulsants, __ intestinal malabsorption, __liver disease (affects conversion of D2 to D3, __renal disease.

Past Surgical History (please check all that apply & approximate date of surgery)

__Abdominoplasty (Tummy Tuck)	__Gastroscopy	__Lung Surgery
__Aortic Aneurysm	__Gastric Bypass	__Neck surgery
__Appendectomy	__Gastric Sleeve	__Pacemaker
__Carotid Surgery, R or L	__Heart Bypass	__Prostate Surgery
__Cataract/Eye	__Heart Angioplasty/Stents	__Shoulder Surgery
__Carpal Tunnel	__Hernia	__Splenectomy (↑DVT, PE)
__Colonoscopy	__Hip Surgery	__Stomach Surgery
__Colon surgery	__Knee Surgery	__Thyroid Surgery
__Facelift	__Laparoscopy, Diagnostic	__Tonsillectomy
__Foot Surgery	__Liposuction	__Vascular Surgery, R or L
__Gallbladder	__Lumbar (Disc) Surgery	__Vein Surgery, R or L

Any Other Surgeries _____

Any prior Transfusions? Y N. Any problems with anesthesia? Y N. Explain _____

Past Medical History (please **check** all that apply) (please circle **Active** for all that are currently being treated)

__Abnormal Healing`	Active	__Gout	Active	__Pancreatitis	Active
__Acid Reflux (GERD)	Active	__Heart Attack	Active	__Scarring/Keloids	Active
__Alcohol abuse history	Active	__Hepatitis	Active	__Seizures	Active
__Anemia	Active	__Hernia	Active	__Shortness of breath	Active
__Anorexia	Active	__High Blood Pressure	Active	__Sinus problems	Active
__Arthritis	Active	__HIV	Active	__Sleep Apnea	Active
__Asthma	Active	__Insomnia	Active	__Stroke/TIA	Active
__Blood Disorder	Active	__Irregular Heart	Active	__Thyroid disease	Active
__Bronchitis	Active	__Kidney disease	Active	__TMJ syndrome	Active
__Cancer	Active	__Liver Disease	Active	__Tuberculosis	Active
__Chest pain (angina)	Active	__Lymphedema	Active	__Ulcers, stomach	Active
__Cold sores	Active	__Malignant Hyperthermia		__Varicose veins	Active
__Dentures	Active	__Motion sickness	Active	__Vision Problems	Active
__Depression	Active	__Nausea/Vomiting	Active		
__Diabetes	Active	__Neuropathy	Active	Other_____	
__Drug abuse history	Active	__Oxygen use	Active	Other_____	
__Fibromyalgia	Active	__Palpitations	Active		

Review of Systems (Please circle all that apply)

- **Constitutional:** Fever, chills, night sweats, trouble swallowing, weight loss/gain _____lbs.. Insomnia.
- **Skin:** Ulcers, Rash, Itching, Cellulitis, Melanoma, Skin Cancer, Eczema, Psoriasis
- **Eyes:** Temporary loss of vision in one eye, Blurred Vision, Cataracts, Glasses, Macular Degeneration.
- **ENT:** Dentures, Ear Problems, Hearing Aid, Nose Bleeds, Congestion, Swallowing Problems
- **Cardiac:** Chest pain with exertion, Palpitations, Leg swelling, Ankle swelling, Leg pain, leg pain at rest, leg pain with activity, last stress test _____, Echocardiogram _____
- **Respiratory:** Short of breath (SOB), Wheezing, SOB when lying flat, Cough, change in voice/hoarseness.

- **GI:** Nausea, Vomiting, Diarrhea (stool per day_____), Constipation (On average, stool every day _____), Abdominal pain, Blood in stool, black stool , Heartburn, acid Reflux, Colon Polyps, generally eat high or low fiber diet, high or low fat diet.
- **GU:** Burning when urinate, frequency, urgency, Prostate problems, Kidney disease, Genital Warts, Herpes
- **Musculoskeletal:** Pain legs/calf with walking, Sciatica, back pain, back disc disease, joint pain, neck pain.
- **Neurologic:** Dizzy, lightheaded, weak or numb one side- arm/leg/face, headache, passing out.
- **Psych:** Depression, Anxiety, Psychosis, Dementia, Bipolar
- **Endocrine:** Excessive thirst or urination, Thyroid disease
- **Heme/Immune:** HIV/AIDS, Hepatitis A, B, C, easy bruising, clotting disorder.

Medications: List all medications, dosages, frequency, and include all natural supplements: _____

_____

_____

Any Diet Pills: Yes No
Latex Allergy: Yes No
Xylocaine "caine" any local anesthetic Allergy: Yes No
Drug Allergies: _____

_____

Seasonal or Environmental Allergies: _____

Social History: Check all that apply: Alcohol _____. How much & When: _____
Tobacco- Smoke _____ Dip _____ Chew ____ How much & how long? _____ Quit, when_____
___ Live Alone, ___ Employed, ___ Disabled, ___ Retired, ___ Student, ___ Homemaker, ___ Married, ___ Divorced, ___ Widowed, ___ Single, ___ Never Married.

Family History: Please specify which family member (s):

□ Hypertensions _____ □ Heart Problems _____ Other Family History:
□ Aneurysm _____ □ Varicose Veins _____
□ Uterine Cancer _____ □ Heart Disease_____
□ Ovarian Cancer _____ □ Osteoporosis _____
□ Breast Cancer _____ □ Diabetes _____
□ Prostate Cancer _____ □ Stroke _____
□ Clotting disorder _____ □ Testicular Cancer: _____

Other Information by Patient _____

_____

_____

_____

_____

_____

Patient Signature: _____ Date: ____/____/_____