CENTER FOR
PELVIC HEALTH AND WELLNESS

Full Name:_____Date of Birth:_____

Reason for visit today (Check all that apply):

□ Low Testosterone/Male Hormone Balance
□ Create a Wellness Lifestyle
□ Lose Weight
□ Sexual Health and Couple Wellness
□ Other _____

Please list your 3 major health goals in order of priority:

1. _____
2. _____
3. _____

Rate your Symptoms:

Symptoms	**Never**	**Mild**	**Mod**	**Severe**
Sweating (night sweats or excessive sweating)	□	□	□	□
Sleep Problems (difficulty falling asleep, sleeping through the night or waking too early)	□	□	□	□
Increased need for sleep or falls asleep after meal	□	□	□	□
Depressive mood (feeling down, sad, lack of drive)	□	□	□	□
Irritability (mood swings, feeling aggressive, angers easily)	□	□	□	□
Anxiety (restless, feeling panicked, nervous, tension)	□	□	□	□
Physical exhaustion (decrease endurance, muscle strength, fatigue, lack of stamina)	□	□	□	□
Sexual problems (change in desire or performance)	□	□	□	□
Bladder problems (difficulty urinating, frequent urination)	□	□	□	□
Erectile changes (weaker, loss of morning erections)	□	□	□	□
Brain fog, Problems with thinking, poor memory	□	□	□	□
Increase frequency of headaches	□	□	□	□
Rapid hair loss or thinning	□	□	□	□
Feel cold all of the time	□	□	□	□
Weight gain, increased belly fat	□	□	□	□
Infrequent or absent ejaculations	□	□	□	□

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Patterns Please mark frequency of activity per week:

Lift weights _____ Exercise _____ Get Outside _____

Skip Meals _____ Enjoy Work____ Sit at Computer _____

Sleep Well _____ Self Care _____ Nicotine _____

Meditate/Prayer ____ Intimacy _____ Move Bowels _____

Hydration What is your average daily intake? (oz)

Water _____ Caffeine ____ Alcohol ____ Soda _____

Juices _____ Milk _____ Energy Drinks____

Other _____

Fuel What % do you eat of the following daily?

Dairy % _____ Fats % _____ Vegetables % _____

Animal protein %_____Grains % _____

Fruit % _____ Processed foods % _____

Wellness Mark the wellness practices you use:

□ Acupuncture □ Chiropractic □ Physical Therapy

□ Yoga □ Massage □ Nutritional Counseling

□ Eye Care □ Exercise/Movement Classes

□ Psychological Services □ Supplements

□ Dental Care □ Regular Check-ups

Past Dietary Changes Check all that apply, what, when?

□ Dietary changes

□ Keto /Paleo

□ Anti-Inflammatory

□ FODMAP

□ Low Fat- Low Carb

□ High Fiber

□ Low Residue

□ Vegan or Plant Based

□ Mediterranean

□ Weight Watchers

□ V-Shred

□ Beach Body

□ Intermittent Fasting, Type _____

□ Other _____

Past Treatments Check all that apply, what, when?

□ Diet Medications _____

□ Diet Supplements _____

□ Liposuction – Cool Sculpt

□ HIFEM (Emsculpt or Emsella)

□ BioTe or Sotopelle Hormone Pellets

□ Bio-identical Hormone Therapy _____

□ Lubricants _____

□ Viagra, Cialis, injectables

□ OShot or PRP

□ Pelvic Physical Therapy

□ Couples or Individual Therapy

□ Other _____

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Patient Name: Date:

MEDICAL HISTORY

Please **check** all that apply: □ I have no medical problems – go to next section.

	Self	Siblings	Mom	Dad	GPs
ADD/ADHD/ASD	□	□	□	□	□
Alcohol	□	□	□	□	□
Alzheimer's Disease	□	□	□	□	□
Anxiety	□	□	□	□	□
Arthritis	□	□	□	□	□
Asthma	□	□	□	□	□
Atrial Fibrillation	□	□	□	□	□
Bleeding Disorders _____	□	□	□	□	□
BPH- Prostate enlargement	□	□	□	□	□
Cancer _____	□	□	□	□	□
Cervical Disc Disease	□	□	□	□	□
Chronic Cough/COPD	□	□	□	□	□
Chronic Fatigue	□	□	□	□	□
Colitis	□	□	□	□	□
Deep Vein Thrombosis	□	□	□	□	□
Depression	□	□	□	□	□
Diabetes	□	□	□	□	□
Drug Addiction	□	□	□	□	□
Eye Conditions _____	□	□	□	□	□
Fibromyalgia	□	□	□	□	□
Gall Bladder Disease	□	□	□	□	□
Gastroesophageal Reflux/Ulcer	□	□	□	□	□
Glaucoma (narrow/wide angle)	□	□	□	□	□
Headaches/Migraines	□	□	□	□	□
Heart Disease _____	□	□	□	□	□
Heart Valves	□	□	□	□	□
Hemorrhoids	□	□	□	□	□

	Self	Siblings	Mom	Dad	GPs
Hepatitis A, B, C	□	□	□	□	□
HIV/AIDS	□	□	□	□	□
Hypothyroidism/Hashimotos	□	□	□	□	□
Hypertension/High Bld Pressure	□	□	□	□	□
Hyperthyroidism/Graves/Goiter	□	□	□	□	□
Hypercholesterolemia	□	□	□	□	□
Immune System- Weak	□	□	□	□	□
Irritable Bowel Syndrome	□	□	□	□	□
Kidney Disease_____	□	□	□	□	□
Lung Disease _____	□	□	□	□	□
Lupus	□	□	□	□	□
Lumbar Disc Disease	□	□	□	□	□
Mental Illness _____	□	□	□	□	□
Multiple Sclerosis	□	□	□	□	□
Myocardial Infarction	□	□	□	□	□
Osteoporosis/osteopenia	□	□	□	□	□
Rheumatic Fever	□	□	□	□	□
Renal Stones	□	□	□	□	□
Seizures	□	□	□	□	□
Sexually Transmitted Infections	□	□	□	□	□
Shingles	□	□	□	□	□
Skin Disorder	□	□	□	□	□
Sleep Disorder/Apnea	□	□	□	□	□
Spinal Cord Injury	□	□	□	□	□
Stroke/TIA	□	□	□	□	□
Varicose Veins	□	□	□	□	□
Other_____					

SURGICAL HISTORY

Please **circle** any surgeries that you have had indicate **year**: □ I have never had surgery- go to next section.

Abdominal Surgery _____
Appendectomy
Abdominoplasty/tummy tuck
Anal/Rectal Surgery_____
Back Surgery _____
CABG _____ x Vessels
Cervical conization/LEEP
Cholecystectomy (removal of the gallbladder)
Facial Surgery _____
Hernia Surgery
Hip Surgery _____Replacement R/L
Knee Surgery_____ Replacement R/L
Laparoscopy, for_____
Pacemaker
Prostate Surgery _____
Removal of Adhesions
Spinal Stimulator/ InterStim
Testicular Surgery _____
Other _____

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Patient Name: Date:

MEDICATIONS Please **list all** current medications, vitamins, supplements If you have a list please provide			
Name	Dosage	How often	Reason for Medication

ALLERGIES Please **list all** allergies, including drugs, iodine, shellfish, latex □ **I have no Drug Allergies**	

SOCIAL HISTORY

Occupation: □ Not currently working outside the home □ Retired □ Working---Vocation_____

Relationship Status: □ Single □ Partnered □ Married, happily- Yes or No □ Separated □ Divorced □ Widowed

Tobacco: □ I have never smoked - go to next section.
□ Quit smoking < 5 years ago 5-10 years ago > 10 years ago
Number of Years using Tobacco _____ Number of Cigarettes per day _____

Alcohol: □ I never drink alcohol - go to next section. □ Drinks per day _____ □ Drinks per week _____

Do you or have you used any of the following:
□ CBD products (edibles, CBD oil, smoking, or topicals) □ Stimulants (cocaine, Adderall) □ Injectables (Heroin)
□ Medications not prescribed to you (opioids (Percocet or Vicodin), sedatives (Valium or Xanax) □ Cigars □ Anabolic steroids

MALE HISTORY

Sexual History	**Prostate Cancer Screening**	**Children**	**Contraceptive History**
Sexual History □ I am not sexually active □ I am sexually active □ I have sexual wellness concerns □ Low sex drive □ Erectile issues □ Premature ejaculation □ Peyronies disease □ Pain with erection □ Sexual Orientation □ Heterosexual □ Homosexual □ Bisexual □ Other	Have you ever had an abnormal PSA? Yes or No Have you had treatment BPH If so: When _____ What treatment _____ Have you had treatment for Prostate Cancer? If so: When _____ What treatment _____ Have you had the HPV vaccine Yes or No **Infection History** Have you ever had? □ Chlamydia □ Gonorrhea □ Herpes □ Other _____	□ I have no children □ I have fathered __ children	□ I am not using contraception I have questions about contraception Yes or No Are you using any birth control now? _____ Past use of: □ Abstinence □ Barrier method (condom) □ Vasectomy □ Depends on partner □ Other

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Patient Name: Date:

REVIEW OF SYSTEMS Please **circle all** symptoms that you currently have **now or in past 2 weeks**:			
Constitutional Chills Fever Weight Gain/Loss Loss of Appetite Fatigue Sleep Disturbance	**Chest** Pain Nipple Discharge Mass	**Respiratory** Cough Shortness of Breath Wheezing/Asthma Use of Inhaler	**Urinary Tract** Frequent Urination Urgency Loss of Urine Frequent Bladder Infections Burning with Urination Blood in Urine Low flow urine Leakage of urine
Eyes Blurred Vision/Double Vision Glasses/Contacts Eye Pain Watery eyes/Itchy Eyes	**Gastrointestinal** Reflux Constipations Diarrhea Nausea/Vomiting Change in Stools Blood in Stools Bloating Stool loss	**Neurologic** Weakness Impaired Balance Headache/Migraines Confusion Numbness/Tingling Memory Loss Brain Fog Learning Disabilities	**Genitourinary** Bent penis Low sex drive Erectile issues Penile discharge Penile pain Testicular pain
Ears/Nose/Throat Dry Mouth Hearing Loss Ringing in the ears Sinus Trouble Sore Throat Denture Use Allergic Symptoms	**Musculoskeletal** Joint Pain Back/Neck Pain Muscle Aches Joint Swelling Fall/Trauma Use of Cane/Walker Tight Muscles Leg Swelling	**Hematologic** Easy Bleeding Easy Bruising Blood Thinners **Endocrine** Increased thirst Changes in Blood Sugars	**Sexual/ Hormone Balance** Lack of Desire Problems with Orgasm Relationship Issues Pain with Intercourse Mood Swings Weight Problems Brain Fog Forgetfulness Mood Changes Sleep Disturbance
Cardiovascular Chest Pain Palpitations/Irregular heart beat Murmur	**Skin** Rash/Itching Increased Hair Growth Hair Loss Acne/Eczema/Dry skin	**Emotional** Anxiety Panic Attacks Depression Irritability	

HEALTH MAINTENANCE:

	Colonoscopy	Bone Density	Health Screen Lab Tests	PSA	Urology Exam
Date of last:	_____	_____	_____	_____	_____