

Jupiter Family Healthcare Anti-Aging and Wellness: MALE

NAME: _____ DATE: _____

E-MAIL ADDRESS _____

Number of living children: _____

Are you sexually active? _____ How many times per week? _____ Problems _____

Date of last physical exam? _____ Any abnormalities? _____

Date of last Prostate Exam _____ Any abnormalities? _____

Date of last PSA? _____ Any Abnormalities? _____

Date of last Bone Density? _____

Current Medications including vitamins:

Hormone Therapy used in the past:

Do you exercise? _____ What type? _____

How often? _____

Do you consider yourself a healthy eater? _____

How do you deal with stressors in your life? (ex: golf, bike riding, reading etc)

How often do you drink alcohol? _____ How much? _____

Do you use recreational drugs? _____ What type? _____

Please check all that apply:

None

Mild

Moderate

Severe

Sleep disturbance _____

Anxiety, Nervousness _____

Irritability _____

Depression/Mood swings _____

Dry skin _____

Muscle Loss _____

Difficulty Maintaining
erection _____

Difficulty achieving erection

Fatigue _____

Concentration Issues _____

Loss of libido/orgasm _____

Joint pain _____

Memory
loss _____

Bowel issues _____

Weight gain _____