Personal Information

Name:	**DOB:**
Home Phone:	**Gender:**
Cell Phone:	**Height:**
Emergency Contact:	**Weight:**
Emergency Contact #	**Email:**
Occupation:	
Address:	

Primary Physician Information

Primary Physician:
Phone:
Fax:
Date of Last Physical Examination:

Medical History

Current Medical Problems: (Please list in space below)
Prior Surgeries and dates of surgeries : (Please list in space below)

Prior Hospitalizations: (Please list in space below)

Current Medications

Name	Dosage	Frequency

Over-the Counter Medications

Name	Dosage	Frequency

Vitamins, Herbals, other Supplements

Name	Dosage	Frequency

Allergic to Medications?	**Yes**		No	

List allergies to any medication: (Please list in space below)

Personal Life Style

Do you Smoke?	**Yes**		**No**	
If yes how much do you smoke?				
Type of Tobacco you use?				
Do you drink Alcohol?	**Yes**		No	
If yes how much do you drink?				

Do you exercise Regularly?	**Yes**		No	
If Yes, please describe:				
Dieting	**Yes**		**No**	
If Yes, please describe:				
Physician-prescribed diet?	**Yes**		**No**	

Caffeine intake?	**None**	**Tea**	**Coffee**	**Soft Drinks**
Number of cups/cans per day?				

Are you sexually active?	**Yes**		**No**	
Are you trying to get pregnant?	**Yes**		**No**	
Do you experience discomfort during intercourse?	**Yes**		**No**	

Are you HIV+ or do you have AIDS?	**Yes**		**No**	

Diagnosed History: Do you currently or have you ever had any of the following? If yes please explain in the space provided below

Heart Attack/Heart Failure	**Yes**		**No**	
Liver Disease	**Yes**		**No**	
Renal Disease	**Yes**		**No**	
Asthma/COPD	**Yes**		**No**	
Thyroid Problems	**Yes**		**No**	
Cholesterol Problems	**Yes**		**No**	
Anemia	**Yes**		**No**	
Cancer	**Yes**		**No**	
Fibromyalgia	**Yes**		**No**	
Anxiety	**Yes**		**No**	
Erectile Dysfunction	**Yes**		**No**	
Back Injury/Problems	**Yes**		**No**	
Diabetes	**Yes**		**No**	
Orthopedic, Muscle Disorder, Fracture, or Joint Disorders	**Yes**		**No**	

If you answered yes to any of the symptoms above, please describe in space provided

Please answer all of the flowing questions

Muscle aches and pains	**Yes**		**No**		**Joint pain during exercise**	**Yes**		**No**	
Increasing back pain	**Yes**		**No**		**Increase in joint pains**	**Yes**		**No**	
Aching/stiff joints in AM	**Yes**		**No**		**Decreased bone mass**	**Yes**		**No**	

Progressive osteoporosis	**Yes**		**No**		**Decreased self confidence**	**Yes**		**No**	
Thinning or loss of hair	**Yes**		**No**		**Decreased sense of well being**	**Yes**		**No**	
Nipple sensitivity	**Yes**		**No**		**Decreased sex drive**	**Yes**		**No**	
Feeling fatigued	**Yes**		**No**		**Decreased endurance**	**Yes**		**No**	
Decreased libido/sex drive	**Yes**		**No**		**Longer recovery time**	**Yes**		**No**	
Decreased muscle strength	**Yes**		**No**		**Decrease in skin tone**	**Yes**		**No**	
Difficulty sleeping	**Yes**		**No**		**Decreased muscle mass**	**Yes**		**No**	
Feeling depressed	**Yes**		**No**		**Decreased testicle size**	**Yes**		**No**	
Decreased motivation	**Yes**		**No**		**Increased fat deposition**	**Yes**		**No**	
Poor/slow wound healing	**Yes**		**No**		**Painful menstrual cycles**	**Yes**		**No**	
Decreased skin elasticity	**Yes**		**No**		**Other form of cancer**	**Yes**		**No**	
Prostate cancer	**Yes**		**No**		**Gastrointestinal bleeding**	**Yes**		**No**	
Decreased energy	**Yes**		**No**		**Using estrogen or BC Pill**	**Yes**		**No**	
Exercising less	**Yes**		**No**		**Hot flushes & night sweats**	**Yes**		**No**	
Increase in skin wrinkles	**Yes**		**No**		**Increased breast size-men**	**Yes**		**No**	

Women Only

Do you suffer from heavy periods, irregular periods, spotting, pain, or severe discharge?	**Yes**		**No**	
Are you pregnant or breastfeeding?	**Yes**		**No**	
Have you had a D&C, Cesarean section, or Hysterectomy?	**Yes**		**No**	
Have you had any bladder or kidney infections in the past?	**Yes**		**No**	

Age at menstruation onset:					
Date of Last Menstrual period:	**Frequency: (days)**		**Duration: (days)**		
Number of Pregnancies:		**Number of live births:**			

Men Only

Are you experiencing difficulty achieving or maintaining erections?	**Yes**		**No**	
Are you experiencing any ejaculatory concerns?	**Yes**		**No**	
Have you recently noted any lumps, tenderness, swelling or pain of your testicles?	**Yes**		**No**	
How many times do you get up to urinate each night?	**Yes**		**No**	
Do you experience burning or pain with urination?	**Yes**		**No**	
Is your urinary stream less forceful than usual?	**Yes**		**No**	
Are you having any problems with penile discharge?	**Yes**		**No**	

Blood testing

Would you like to have a food allergy test included with your blood work?	Yes		No	
Would you like to process blood work thru insurance?	**Yes**		**No**	
By signing the space provided to the right. I, _____understand that I am liable for any additional cost of lab work. Neither Androgenix LLC. and/or the lab, can or will be held accountable for any lab work not covered by my insurance provider.				

Family Health History

Family Member	**Age or Age at Death**	**Medical Problems**
Grandparents:		
Father:		
Mother:		
Sister:		
Brother:		

I, _____hereby acknowledge that all the information I have provided above is accurate to the best of my knowledge.

Signature:_____

Date:_____