

Confidential Medical History Form

I REALIZE THIS MEDICAL HISTORY FORM IS SOMEWHAT LONG. HOWEVER, IT IS ABSOLUTELY NECESSARY FOR ME TO EVALUATE YOUR GENERAL HEALTH. MAKE SURE TO TAKE A FEW MINUTES TO CAREFULLY AND COMPLETELY ANSWER EVERY QUESTION. FAILING TO DO SO WILL PREVENT ME FROM HELPING YOU AS WELL AS I COULD. DO THE BEST YOU CAN- I WILL FOLLOW-UP WITH ANY QUESTIONS I MAY HAVE. REMEMBER, THIS INFORMATION IS COMPLETELY CONFIDENTIAL.

Please initial here that you have read the above statement: _____

First name: _____

Middle name: _____

Last name: _____

Address: _____

City: _____

State: _____

Zip code: _____

CONTACT INFORMATION

Email: _____

Repeat Email Address [to confirm]: _____

Day time phone: _____

Night time phone: _____

PERSONAL INFORMATION

Birth date: _____

Marital Status (Married, Divorced, Never Married, Gay) _____

Sex: _____

Height: _____

Weight: _____

Do you have a primary care physician? _____

When was your last complete physical examination? _____

What were the results of that exam? _____

Will you have a copy of that report and any labs sent to ME (email, mail or fax)?

(FOR OVER 40) Did you have your prostate examined? _____

(FOR OVER 40) Did you have your PSA checked? _____

If so, what was it? _____

PAST MEDICAL HISTORY

Please indicate if you now have, or have EVER had:

Anemia

Arthritis

Asthma

Blood disease

Bronchitis

Diabetes

Emphysema

Epilepsy

Gout

Hepatitis

Heart disease

High blood pressure

High cholesterol

Kidney disease

Migraines

Mononucleosis

Pneumonia

Psychological problems

Rheumatic fever

Seizures

Stroke

Thyroid disease

TB

Ulcers

Urinary tract infections

Have you ever had any form of cancer? _____

If so, please detail: _____

PAST SURGICAL HISTORY

What surgeries have you had?

Prostatectomy

Hernia repair

Other surgeries (please explain): _____

Have you ever been hospitalized (other than for the above mentioned surgeries)?""P q

If so, please list the reason and give approximate date(s)=

_____aaaaaaaaaaaaaaaaaaaaaaaaaaaa

FAMILY MEDICAL HISTORY

Have your brothers and/or sisters, parents or grandparents, ever had (Please tell which family member(s))?

Heart attack

Diabetes

Kidney disease

Leukemia

Mental disorders

Stroke

Prostate cancer

Other cancer _____

Please detail ANY of the above: _____

74. Are you allergic to anything? _____

75. If yes, what? _____

76. Do you smoke? _____

77. If so, how much each day? _____

78. How long have you smoked? _____

79. Do you drink alcohol? _____

How many drinks do you typically have in a week? _____

80. Do you use any illicit substances (get high)- confidential and important?

If so, which ones? _____aaaaaaaaaaaaaaaaaaaaaaaaaaaa

REVIEW OF SYSTEMS

Do you CURRENTLY have?:

Head aches

Vision changes

Hearing changes

Chronic sinusitis

Allergic sinus problems

Any tenderness or sores in your mouth or throat

Bloody noses

Chronic cough

Do you spit up blood?

Shortness of breath

Chest pain

Dizziness

Congestive heart failure

Palpitations

Any form of arrhythmia

Heart murmur

Recurring constipation

Recurring diarrhea

Gallbladder disease

Throw up blood

Blood in your stool or black tarry stool

Hernia

Loss of appetite

Indigestion

Nausea

Vomiting

Night sweats

Jaundice (yellow skin)

Do your eyes look yellow? _____

Do you have abdominal pain? _____

If so, please describe and tell where: _____

Pancreatitis _____

Do you urinate alright? _____

How many times do you get up at night to urinate ? _____

Does it hurt when you urinate? _____

Is there any blood in your urine? _____

Have you ever had a STD (Sexually Transmitted Disease)? _____

Have you had prostatitis in the past? _____

Tingling in your fingers or toes? _____

Acne

Describe any acne history: _____

Do you ever pass out? _____

Do you have cold intolerance? _____

Do you bruise easily? _____

Depression _____

Anxiety _____

Decreased sexual potency ? _____

If so, is this causing stress in your relationship? _____

Sleep disturbances

Generalized muscle aches and pains

Joint pain

Back pain

Fatigue

Lethargy

Sensitive or swollen nipples? _____

Did you have swollen or painful nipples BEFORE you ever used steroids (for Steroid Consult only)?

Can you feel any lumps around your nipples ? _____

Are you losing your hair? _____

Were you losing it before you started using steroids (AAS Consult only)? ____ If so, is it
falling out more quickly now? _____

GENERAL

Loss of appetite _____

Unexplained weight loss or weight gain ? which ? _____

Do you consider yourself to be in good health? _____

Do you sleep well? _____

Average hours of sleep per night: _____

Do you regularly self examine your testicles? _____

Tell me about your diet (Details please)=

MEDICATIONS

140. Do you take any prescription medications (other than steroids)? _____

If so, please list, and give dosages=

#147 If so, please describe=

HRT patients only (questions 150-159):

Do you plan on having more children? _____

Do you have a decrease in sex drive? _____

If the answer to #151 is "YES", is this affecting your relationship? _____

Has your strength or endurance decreased? _____

Are you enjoying life less? _____

Are you sad or grumpy? _____

Are your erections less strong? _____

Has your work performance decreased? _____

Do you have a hard time recovering from physical activity? _____

Have you ever been on testosterone replacement before? _____ If yes, what kind of product did you use and for how long? _____

The information that I will receive in the consultation is for educational purposes only, and is in no way a substitute for the advice of a qualified health care provider. I understand that appropriate medical therapy and the use of pharmaceutical compounds like testosterone should be tailored for the individual, as no two individuals are alike. I understand that Nelson Vergel does not recommend self-medicating with any compound, as I should consult with a qualified medical doctor who can determine my individual situation. I understand that any use of the information presented to me in the consultation is done strictly at my own risk and no responsibility is implied or intended on the part of Nelson Vergel.

Signed: _____

Date: _____