OPTIMAL VITALITY
Male Intake Form

Name	**Date of Birth**	**Age**
Street Address	**City, State, Zip Code**	**Best Phone to Reach You**
Cell Phone	**Can We Leave A Message/text?**	**Email**
Employer	**Occupation**	**Spouse / Partner**
Emergency Contact/Phone	**Primary Care Physician**	**Referred By**
Height	**Weight**	

Medical History	**Self**	**Family**		**Self**	**Family**		**Self**	**Family**
Seizures			Asthma/COPD			Diarrhea		
Migraines or Headaches			Sleep Apnea			Liver Disease		
Dizziness			Pulmonary Hypertension			Gallbladder Disease/ Stones		
Loss of Consciousness			Shortness of Breath			Ulcers		
Stroke			Irregular Heart Rhythm			Colitis		
Glaucoma			Heart Attack or Angina			Constipation		
Thyroid Disorder			Palpitations			Arthritis		

Patient Signature_____Date_____

Provider Signature _____Date_____

Patient Name_____DOB_____

Obesity/Overweight			Heart Valve Disorder			Gout		
Diabetes Mellitus (DM)			Heart Failure			Osteopenia or Osteoporosis		
High Blood Sugar			High Blood Pressure			Kidney Disease or Stones		
Abnormal Cholesterol			Rheumatic Fever			Alcohol Abuse		
Insomnia			Tuberculosis			Drug Abuse		
Dementia			HIV			Eating Disorder		
Other:			Cancer Type:			Other Psychiatric Illness		

ALLERGIES List all allergies to medications and reactions.

Medication	Reaction

Latex Allergy ( ) No ( ) Yes

CURRENT MEDICATIONS

Name of Medication	Dose Milligrams or Micrograms	# of Pills Daily	Date Started

CURRENT SUPPLEMENTS (Vitamins, Minerals, Herbs, etc)

Patient Signature_____Date_____

Provider Signature _____Date_____

Patient Name_____DOB_____

Name of Supplement	Dose Milligrams or Micrograms	# of Pills Daily	Date Started

PREVIOUS SURGERIES

Surgery / Procedure	Date

MEDICAL CARE	**DATE**	**RESULTS OR FINDINGS**
Physical Exam		
Rectal Exam		
PSA		
Colonoscopy		
Cholesterol Check		
Cardiac Test (EKG, Echo, Stress, etc.)		

DIET AND LIFESTYLE

List dietary restrictions or food allergies: _____

Describe typical meals:

Breakfast	
Lunch	

Patient Signature_____Date_____

Provider Signature _____Date_____

Patient Name_____DOB_____

Dinner	
Snacks	

HABITS	**Yes**	**No**	**Amount / Type**
Do you get regular exercise?			
Do you consume alcohol?			
Exercise regularly?			
Experience excessive stress?			

REVIEW OF SYSTEMS

Please check YES to any symptom that you experience. For any YES answer please provide a brief description.

	Yes	If Yes, list physician you have seen and describe your condition and how long you have had it
Fever /Chills		
Excess Fatigue		
Weight Loss/Gain		
Frequent Bruising		
Blurry Vision		
Frequent Bruising		
Enlarged Lymph Nodes		
Frequent Infections		
Cardiovascular		
Chest Pain at Rest or Exercise		
Cold Hands /Feet		
Swelling of Legs or Leg Cramps with Walking		

Patient Signature_____Date_____

Provider Signature _____Date_____

Patient Name_____DOB_____

Heart Attack/Failure/Angina		
Mitral Valve / Murmur		
High Blood Pressure		
Gastrointestinal		
Constipation		
Diarrhea		
Bloating		
Excessive Belching		
Gas / Acidity		
Heartburn / Indigestion		
Ulcers		
Nausea / Vomiting		
Blood in Stool		
Thirst: Lack of / Too Much		
Genitourinary		
Pain on Urination		
Cloudy / Bloody Urination		
Urinating Too Often		
Difficulty Urinating		
Loss of Urine		
Musculoskeletal		
Do you see a Chiropractor?		
Get regular body treatment/ massage?		
Back or Neck Pain		

Patient Signature_____Date_____

Provider Signature _____Date_____

Patient Name_____DOB_____

Joint Pain		
Weakness		
Prone to Falls		
Joint Deformity		
Ears, Nose, and Throat		
Ringing in Ears		
Hearing Difficulty / Loss		
Mouth Sores		
Nasal Stuffiness / Drainage		
Hoarseness		
Teeth or Gum Problems		
Snoring		
Sleep Apnea		
Pulmonary		
Shortness of Breath/Difficulty Breathing		
Persistent Cough		
Asthma / Wheezing		
Night Sweats		
Fever / Chills		
Skin		
Rashes		
Dry / Itchy Skin		
Acne		
Moles / Lesion Changes		

Patient Signature_____Date_____

Provider Signature _____Date_____

Patient Name_____DOB_____

Skin Color Changes		
Skin Growths / Cancer		
Hair / Nail Problems		
Neurologic		
Headaches / Migraines		
Dizziness / Nausea		
Fainting / Blackouts		
Numbness / Tingling		
Paralysis		
Coordination Problems		
Psychiatric		
Mental Illness		
Anxiety		
Depression		
Suicidal Thoughts		
Hallucinations		
Phobias		

Adam Questionnaire

	Yes	**No**
1. Do you have a decrease in libido (sex drive)?		
2. Do you have a lack of energy?		
3. Do you have a decrease in strength and/or endurance?		
4. Have you lost height?		
5. Have you noticed a decreased "enjoyment of life"?		

Patient Signature_____Date_____

Provider Signature _____Date_____

Patient Name_____DOB_____

6. Are you sad and/or grumpy?		
7. Are your erections less strong?		
8. Have you noticed a recent deterioration in your ability to play sports?		
9. Are you falling asleep after dinner?		
10. Has there been a recent deterioration in your work performance?		

Patient Signature_____Date_____

Provider Signature _____Date_____