NEXTGEN
MALE MEDICAL CLINIC
CHANGING THE FUTURE OF MEN'S HEALTH & WELLNESS

Medical History

Patient Name: ____
Last First Middle

Date of Birth: ____/____/____ Sex: ☐ Male / ☐ Female

1) Are you allergic to any medications? ☐ Yes / ☐ No

If yes, please list: ____

2) Are you currently on any medications? (also list over-the-counter, such as vitamins or inhalers) ☐ Yes / ☐ No

3) Are you currently on any anti-depressants? ☐ Yes / ☐ No

If yes to questions 2 or 3, please list:

Medication	Dose	How Often	Reason	Prescribing M.D.

4) When was your last physical/check-up? ______________________________

5) Have you ever or are you currently on any form of testosterone or anabolic steroid?
☐ Yes / ☐ No

Do you have a history of these?	YES	NO	DO NOT KNOW	If yes to any of these, please provide more information:
Cancer	☐	☐	☐	
Diabetes	☐	☐	☐	
Heart Murmur/Palpitations	☐	☐	☐	
Depression	☐	☐	☐	
Heart Disease	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
Thyroid Disease	☐	☐	☐	
Abnormal PSA Test or Prostate Exam	☐	☐	☐	
OTHER	☐	☐	☐	

Any other Medical History we should be aware of? ______________________________

List any surgeries you have had: ______________________________

Do you smoke? ☐ Yes / ☐ No If yes, how much per day? __________

Do you drink alcohol? ☐ Yes / ☐ No If yes, how many drinks per week? __________

Do you exercise? ☐ Rarely / ☐ Sometimes / ☐ Frequently / ☐ Everyday

Signature: ______________________________ Date: ____/____/____