

Well Balance Center

1110 East Austin St.
Paris, Texas 75460
Phone: (903) 785-6156
Fax: (903) 785-6740

Male Patient Information

Name: _____
First Middle Last Name Used

Date of Birth: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

E-mail address? _____

Employed By: _____

Marital Status: Married Divorced Single Widow Living With Sig. Other

Spouse's Name: _____
First Last

Spouse's Date of Birth: _____ Social Security #: _____

Spouse's Employer: _____ Business Phone: _____

In case of an emergency, whom should we notify? _____

Do you have a Family Doctor? _____

Phone number(s): _____

Thank you for selecting Dr. Zimmerman for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience we accept Visa, MasterCard, cash and checks.

I AGREE THAT SHOULD THIS ACCOUNT BE REFERRED TO AN AGENCY OR ATTORNEY FOR COLLECTION, I WILL BE RESPONSIBLE FOR ALL COLLECTION COSTS, ATTORNEY'S FEES, AND COURT COSTS.

Signature: _____ Date: _____

SEXUAL HISTORY

1. Age of first sexual contact _____

2. Are you sexually active? YES NO
3. Do you have history of sexually transmitted diseases? YES NO
If yes, please list: _____
4. Have you had the mumps? YES NO
Year: _____
5. Are you HIV positive? YES NO
Had Treatment? YES NO
6. Have you ever been tested for AIDS? YES NO
Results: _____
7. Have you fathered any children? YES NO
If yes, how many? _____
8. Sexual Orientation Heterosexual Homosexual Bisexual
9. Have you had testicular cancer? YES NO
Year: _____
10. Do you have or had prostate problems? YES NO
11. Have you had blood in your urine? YES NO
Last _____
- Date: _____
12. Do you have erectile dysfunction? YES NO
If yes, please describe: _____
13. Do you initiate intercourse? YES NO
14. Is intercourse satisfying? YES NO
15. Do you achieve orgasm? YES NO
16. How often do you have intercourse? _____
17. Is your sex drive the same as it was five years ago? YES NO
18. List any other sexual dysfunctions: _____
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19. Have you experienced weight gain in the last one-two years? YES NO
20. Have you lost greater than 10 pounds in less than a month? YES NO
21. Have you had your testosterone level taken? YES NO
22. List current medications: _____

PAST MEDICAL HISTORY
Please check all that apply:

- | | |
|--|---|
| <input type="checkbox"/> diabetes | <input type="checkbox"/> lupus/arthritis |
| <input type="checkbox"/> hypertension | <input type="checkbox"/> heart disease |
| <input type="checkbox"/> heart murmur | <input type="checkbox"/> rheumatic fever |
| <input type="checkbox"/> mitral valve prolapse | <input type="checkbox"/> kidney disease |
| <input type="checkbox"/> urinary tract infection | <input type="checkbox"/> psychiatric problems |
| <input type="checkbox"/> hepatitis/liver disease | <input type="checkbox"/> varicosities/phlebitis |
| <input type="checkbox"/> thyroid problems | <input type="checkbox"/> major accidents |
| <input type="checkbox"/> blood transfusions | <input type="checkbox"/> asthma/lung disease |

1. Do you have any Drug Allergies? YES NO
If yes, please list: _____

2. Please list any surgeries: _____

3. Please list any other hospitalizations (include year & reason): _____

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4. Have you had any anesthesia complications? YES NO
If yes, please list: _____
5. Have you ever been anemic? YES NO
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SOCIAL HISTORY

1. Do you smoke cigarettes/smokeless tobacco/dip/chew? YES NO
If yes, how many per day? _____ Number of years? _____
2. Do you use street drugs? YES NO
If yes what drugs? _____
3. Do you drink alcohol? YES NO
If yes, how much per day? _____
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FAMILY HISTORY

1. Do you have a family history of breast cancer? YES NO
If yes, whom? _____
2. Do you have a family history of colon cancer? YES NO
If yes, whom? _____
3. Do you have a family history of osteoporosis? YES NO
If yes, whom? _____
4. Do you have a family history of diabetes? YES NO
If yes, whom? _____
5. Do you have a family history of hypertension? YES NO
If yes, whom? _____
6. Do you have a family history of heart disease? YES NO
If yes, whom? _____
7. Do you have a family history of kidney disease? YES NO
If yes, whom? _____
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