



## SEXUAL HISTORY

1. Age of first sexual contact: \_\_\_\_\_
2. Are you sexually active?  YES  NO
3. Do you have a history of Sexually Transmitted Diseases?  YES  NO  
If yes, please list: \_\_\_\_\_
4. Have you had a sperm count?  YES  NO  
Results: \_\_\_\_\_
5. Have you had the Mumps?  YES  NO  
Date: \_\_\_\_\_
6. Have you had Testicular Cancer?  YES  NO  
Date: \_\_\_\_\_
7. Do you have Prostate Problems?  YES  NO  
If yes, please describe: \_\_\_\_\_
8. Have you had blood in your urine?  YES  NO  
If yes, when & treatment: \_\_\_\_\_
9. Have you had any bladder or kidney problems?  YES  NO  
If yes, when & treatment: \_\_\_\_\_
10. Do you have erectile dysfunction?  YES  NO  
If yes, please describe: \_\_\_\_\_
11. Do you have:
  - Fatigue?  YES  NO
  - Decrease of memory?  YES  NO
  - Decrease of energy level?  YES  NO
  - Decrease of sexual drive?  YES  NO
12. Do you suffer from:
  - Anxiety?  YES  NO
  - Irritability?  YES  NO
  - Mood swings?  YES  NO
  - Migraines?  YES  NO
13. How have you dealt with these symptoms?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
14. Do you initiate intercourse?  YES  NO
15. Is intercourse satisfying?  YES  NO
16. Do you achieve orgasm?  YES  NO
17. Do you suffer from premature ejaculation?  YES  NO
18. How often do you have intercourse?  
\_\_\_\_\_  
\_\_\_\_\_
19. Is your sex drive the same as it was five years ago?  YES  NO  
Describe: \_\_\_\_\_

20. List any other sexual dysfunctions:

---

---

21. Have you experienced weight gain in the last one-two years?  YES  NO

If yes, please describe: \_\_\_\_\_

22. Have you lost greater than 10 pounds in less than a month?  YES  NO

If yes, why? \_\_\_\_\_

23. Are you HIV positive?  YES  NO

If yes, when? Describe: \_\_\_\_\_

24. Have you ever been tested for AIDS?  YES  NO

Results? \_\_\_\_\_

25. Have you fathered any children?  YES  NO

If yes, how many? \_\_\_\_\_

26. Have you had your Testosterone level taken?  YES  NO

27. List current medications:

---

---

28. Sexual Orientation?

Heterosexual

Homosexual

Bisexual

### PAST MEDICAL HISTORY

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| 1. Do you have diabetes?                                | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. Do you have/had hypertension?                        | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. Do you have heart disease?                           | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4. Do you have a heart murmur?                          | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 5. Do you have/had kidney disease?                      | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 6. Have you ever been treated for psychiatric problems? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 7. Have you ever had rheumatic fever?                   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 8. Do you have mitral valve prolapse?                   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 9. Have you ever had a urinary tract infection?         | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 10. Have you ever had hepatitis/liver disease?          | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 11. Have you ever had varicosities/phlebitis?           | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 12. Do you have any thyroid problems?                   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 13. Have you had any major accidents?                   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 14. Have you ever had any blood transfusions?           | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 15. Do you have asthma/lung disease?                    | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 16. Do you have lupus?                                  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 17. Do you have arthritis?                              | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

18. Do you have any Drug Allergies?  YES  NO

If yes, please list: \_\_\_\_\_

19. Please list any surgeries: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

20. Please list any other operations/hospitalizations (include year & reason):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

21. Have you had any anesthesia complications:  YES  NO

If yes, please list: \_\_\_\_\_

22. Have you ever been anemic?  YES  NO

23. Do you have an Internist or Family Doctor?  YES  NO

Please list name, phone number:

\_\_\_\_\_

\_\_\_\_\_

24. Have you had your cholesterol checked?  YES  NO

If yes, date last checked? \_\_\_\_\_

Was it normal?  YES  NO

### SOCIAL HISTORY

1. Do you smoke cigarettes?  YES  NO

If yes, number per day? \_\_\_\_\_ Number of years? \_\_\_\_\_

2. Do you use street drugs?  YES  NO

3. Do you drink alcohol?  YES  NO

If yes, how much per day? \_\_\_\_\_

## FAMILY HISTORY

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| 1. Do you have a family history of breast cancer?<br>If yes, whom? _____  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. Do you have a family history of colon cancer?<br>If yes, whom? _____   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. Do you have a family history of ovarian cancer?<br>If yes, whom? _____ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4. Do you have a family history of osteoporosis?<br>If yes, whom? _____   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 5. Do you have a family history of diabetes?<br>If yes, whom? _____       | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 6. Do you have a family history of hypertension?<br>If yes, whom? _____   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 7. Do you have a family history of heart disease?<br>If yes, whom? _____  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 8. Do you have a family history of kidney disease?<br>If yes, whom? _____ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

## PATIENT CONSENT TO LEAVE DETAILED MESSAGE/INFORMATION

Dear Patient:

Dr. Byers requires our staff to obtain prior authorization to leave voice mail/messages for the patient. This policy is to protect the patient and also to protect our staff from violating the patient's confidentiality. If we do not have a signed consent form on file, the staff may leave only their name and a phone number on an answering machine asking you to call them back.

By completing the consent below, you hereby authorize the staff to call and leave their name, doctor's name, and additional information on an answering machine or with a specific individual. Unless notified in writing, this consent will remain in effect permanently.

I give my consent to Dr. Byers and/or staff to leave a message regarding treatment, test results or other necessary information.

- 1) On answering machine at home: \_\_\_\_\_
- 2) On voice mail at work: \_\_\_\_\_
- 3) On cell phone voice mail: \_\_\_\_\_

**Please print phone number on lines**

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

**I DO NOT** consent to any messages being left on an answering machine other than caller's name and phone number.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

Thank You for choosing Dr. Byers as your SottoPelle certified doctor.

Please give the nature or your referral:

Person \_\_\_\_\_

Other \_\_\_\_\_

Please understand that the pellets cannot be removed after insertion.

Any questions please direct to Dr. Byers during your consult.

Thank You Again,  
Byers Wellness Center

We must have all paperwork into the office before we can schedule any consultation or insert. This will help make your visit with us alot smoother.

Thank you for your cooperation.

We look forward to your visit with us.

Byers Wellness Center

770-387-3450