# Vital Transitions Clinic

*Helping you embrace the changes in your life*

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## New Patient Registration Form – Male

**PLEASE PRINT**

**DATE: _____**

**SURNAME:_____ FIRST NAME: _____**

**DATE OF BIRTH (dd/mm/yyyy): _____**

**ADDRESS:**

**_____**

**CITY: _____ PROVINCE: _____ POSTAL CODE: _____**

**HOME TEL: _____ BUS. TEL: _____**

**MOBILE: _____ EMAIL: _____**

**OHIP NO: _____ VERSION CODE: _____**

**MARITAL STATUS: _____ CHILDREN :____**

**OCCUPATION: _____**

**HOW DID YOU HEAR ABOUT THIS CLINIC?**

**_____**

**NAME OF CONTACT IN CASE OF EMERGENCY (AND TEL. NUMBER):**

**_____**

**SMOKER ? NO ___ YES ___**

**ALCOHOL CONSUMPTION: _____**

**FAMILY HEALTH HISTORY (Note cause of death if deceased):**

**MOTHER:**_____

**FATHER:**_____

**OTHER RELEVANT FAMILY HISTORY:**_____

**MEDICAL HISTORY: Please check the Following that apply to you:**

___High Blood Pressure

___High Cholesterol

___ Erectile Dysfunction

___ Asthma/COPD

___Cardiovascular Disease

___ Insomnia

___ Diabetes Mellitus

___ Malnutrition

___ Osteoporosis

___ Depression

___ Benign Prostatic Hyperplasia

___ Cancer: _____

___ Other: _____

**LIST OF MEDICATIONS (DOSAGES/FREQUENCY/FOR WHAT REASON):**

_____

_____

_____

_____

_____

_____

**DRUG ALLERGIES:**

_____

_____

**SYMPTOMS:**

**Circle Yes or No to the following questions. If yes, indicate if Mild, Moderate or Severe**

1. Do you feel more fatigued and/or tired than usual? Yes No
   If yes, circle Mild Moderate Severe

2. Have you noticed a decrease in your muscle mass? Yes No
   If yes, circle Mild Moderate Severe

3. Have you experienced a loss in muscle strength? Yes No
   If yes, circle Mild Moderate Severe

4. Have you experienced an increase in joint and/or muscle pains? Yes No
   If yes, circle Mild Moderate Severe

5. Have you noticed an increase in your waist size? Yes No
   If yes, circle Mild Moderate Severe

6. Do you have trouble losing weight? Yes No
   If yes, circle Mild Moderate Severe

7. Have you experienced a loss in height? Yes No
   If yes, circle Mild Moderate Severe

8. Do you have a decrease in your sex drive? Yes No
   If yes, circle Mild Moderate Severe

9. Have you experienced difficulty in establishing or maintaining full erections? Yes No
   If yes, circle Mild Moderate Severe

10. Do you have a decrease in spontaneous morning erections? Yes No
    If yes, circle Mild Moderate Severe

11. Have you experienced changed in your usual sleep pattern? Yes No
    If yes, circle Mild Moderate Severe

12. Do you feel a decrease in your mental sharpness? Yes No
    If yes, circle Mild Moderate Severe

13. Have you had trouble concentrating? Yes No
    If yes, circle Mild Moderate Severe

14. Do you experience less enjoyment in personal interests and hobbies? Yes No
    If yes, circle Mild Moderate Severe

15. I am _____years old. I feel _____years old.

_____ _____

(Signature ) (Date)