

**Jupiter Family Healthcare Anti-Aging and Wellness: MALE**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

Number of living children: \_\_\_\_\_

Are you sexually active? \_\_\_\_\_ How many times per week? \_\_\_\_\_ Problems \_\_\_\_\_

Date of last physical exam? \_\_\_\_\_ Any abnormalities? \_\_\_\_\_

Date of last Prostate Exam \_\_\_\_\_ Any abnormalities? \_\_\_\_\_

Date of last PSA? \_\_\_\_\_ Any Abnormalities? \_\_\_\_\_

Date of last Bone Density? \_\_\_\_\_

Current Medications including vitamins:

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Hormone Therapy used in the past:

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Do you exercise? \_\_\_\_\_ What type? \_\_\_\_\_

How often? \_\_\_\_\_

Do you consider yourself a healthy eater? \_\_\_\_\_

How do you deal with stressors in your life? ( ex: golf, bike riding, reading etc)

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How often do you drink alcohol? \_\_\_\_\_ How much? \_\_\_\_\_

Do you use recreational drugs? \_\_\_\_\_ What type? \_\_\_\_\_

Please check all that apply:

None

Mild

Moderate

Severe

Sleep disturbance \_\_\_\_\_

Anxiety, Nervousness \_\_\_\_\_

Irritability \_\_\_\_\_

Depression/Mood swings \_\_\_\_\_

Dry skin \_\_\_\_\_

Muscle Loss \_\_\_\_\_

Difficulty Maintaining  
erection \_\_\_\_\_

Difficulty achieving erection  
\_\_\_\_\_

Fatigue \_\_\_\_\_

Concentration Issues \_\_\_\_\_

Loss of libido/orgasm \_\_\_\_\_

Joint pain \_\_\_\_\_

Memory  
loss \_\_\_\_\_

Bowel issues \_\_\_\_\_

Weight gain \_\_\_\_\_