Male Patient Questionnaire & History

Name: _____ Today's Date: _____
(Last) (First) (MI)

DOB: _____ Age: _____ Occupation: _____

Home Address: _____ SSN: _____

City: _____ State: _____ Zip Code: _____

Cell phone#: _____ Work phone#: _____
E-Mail address: _____May we contact you via E-Mail? ( )**YES** ( )**NO**

Preferred Pharmacy: _____ Pharmacy telephone#: _____

Insurance information for Lab order purposes:

Primary Insurance Company: _____ Name of Insured: _____
Mailing address: _____ City: _____ State: ___ Zip: _____

Relationship to Insured: _____ Insured's DOB: _____

Policy#: _____ Group Name/Number: _____

In Case of Emergency Contact: _____ Relationship: _____
Contact number: _____

PCP's Name: _____ Phone#: _____
Address: _____ City: _____ State: ____ Zip: _____

Marital Status (check one): ( )Married ( )Divorced ( )Widow ( )Living with Partner ( )Single

In the event we cannot contact you by the mean's you've provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By providing the information below, you are giving us permission to speak with your spouse or significant other about your treatment.

Name: _____Relationship: _____
Contact number(s): _____