APOLLO
MEN'S HEALTH
A BETTER YOU STARTS TODAY

TESTOSTERONE MANAGEMENT INITIAL EVALUATION

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____ Apt/Suite#: _____

DOB: _____(mm/dd/yyyy) SS#:_____ Any known drug allergies? _____

Preferred Phone: _____ Email: _____

Last Physical Exam: _____ Do you get dizzy, freak out, and or faint during blood draw? _____

Are you currently or have you recently been on testosterone treatment? Yes_____ No_____

How did you hear about us? Website Social Media Google ESPN 97.5FM Other_____

Tell Us More About Your Symptoms

___ Decreased Erections ___ Breast Tenderness ___ Decreased Testicular Size

___ Decreased Libido ___ Scanty Pubic Hair ___ Hot Flashes

___ Gynecomastia ___ Unusual Sweating ___ Testicles that are less than 2.5cm in length

What About These Symptoms?

___ Fatigue ___ Mood Changes ___ Decreased Mental Focus ____ Weight Gain

*Do you plan to have more children? __ Yes __ No

___ I authorize the medical staff at Apollo Men's Health to obtain a blood sample to determine my total testosterone, free testosterone, and PSA level.
___ I agree to pay Apollo Men's Health a rate of $75 for this initial evaluation today.

Patient Signature: _____ Date: _____

FOR OFFICE USE ONLY

Height: _____ Weight: _____ BP: _____/_____ HR: _____ RR: _____

Date: _____ Time of Blood Draw: _____ MA Initials: _____

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