



Male Patient Information

Name: _____
Last First Middle

Today's date: _____

Date of Birth: _____ Social Security #: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Numbers: Home: _____ Cell: _____

Do you have an e-mail address you can share with us? _____

Patient employed by: _____

Business address: _____

Business phone: _____

Marital status: (please circle) Married Divorced Single Widow Living with significant other

Spouse's name: _____

Spouse's date of birth: _____ Social Security #: _____

Spouse employed by: _____ Business phone: _____

In case of emergency, whom should we notify: _____

Phone numbers: _____

*Is it ok to leave a message with lab work results on your voice-mail: (please circle) Yes No

** What phone number would you like us to call with lab results and/or appointment reminders?

Phone #: _____

*******Payment is due at time of service*******

Payment types accepted: Cash, Check, Visa, Mastercard, & Discover

(Sorry we do not accept American Express)

What is your primary health concern or reason for considering bioidentical hormone replacement therapy? _____

SEXUAL HISTORY

1. Are you sexually active? YES NO
2. Have you had the mumps? YES NO

Date: _____

3. Have you had testicular cancer? YES NO

Date: _____

4. Do you have prostate problems? YES NO

If yes, please describe: _____

5. Have you had any bladder or kidney problems? YES NO

If yes, when & treatment: _____

6. Do you have erectile dysfunction? YES NO

If yes, please describe: _____

7. Do you have:

Fatigue? YES NO

Decrease of memory? YES NO

Decrease of energy level? YES NO

Decrease of sexual drive? YES NO

8. Do you suffer from:

Anxiety? YES NO

Irritability? YES NO

Mood swings? YES NO

Migraines? YES NO

9. How have you dealt with these symptoms?

10. Is your sex drive the same as it was five years ago? YES NO

Describe: _____

11. List any other sexual dysfunctions:

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

If yes, please describe: _____

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

If yes, why? _____

14. Have you fathered any children? YES NO

If yes, how many? _____

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

Date: _____

16. List current medications:

PAST MEDICAL HISTORY

1. Do you have diabetes? YES NO

2. Do you have/had hypertension? YES NO

3. Do you have heart disease? YES NO

4. Do you have a heart murmur? YES NO

5. Do you have/had kidney disease? YES NO

6. Have you ever been treated for psychiatric problems? YES NO

7. Have you ever had rheumatic fever? YES NO

8. Do you have mitral valve prolapse? YES NO

9. Have you ever had a urinary tract infection? YES NO

10. Have you ever had hepatitis/liver disease? YES NO

11. Have you ever had varicosities/phlebitis? YES NO

12. Do you have any thyroid problems? YES NO

13. Have you had any major accidents? YES NO

14. Have you ever had any blood transfusions? YES NO

15. Do you have asthma/lung disease? YES NO
16. Do you have lupus? YES NO
17. Do you have arthritis? YES NO
18. Do you have any Drug Allergies? YES NO

If yes, please list: _____

19. List any surgeries:

20. 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

If yes, 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 drink alcohol? YES NO

If yes, how much per day? _____

Purposely Left Blank

Hormone Imbalance Checklist

Name: _____ Date: _____

New Patients: Please indicate current symptoms with an X.

Follow-up Patients: Please indicate changes in your symptoms since your initial visit. Use a scale of 0 - 10, with 10 meaning there has been no change in symptoms and 0 meaning symptom has completely been relieved.

- | | | |
|--------------------------------|----------------------------------|---------------------------------|
| _____ Burned-out feeling | _____ Weight gain in waist | _____ Irregular Menstruation |
| _____ Foggy thinking | _____ Inability to lose weight | _____ Vaginal Dryness |
| _____ Anxiety | _____ Hot flashes | _____ Decreased libido |
| _____ Stress | _____ Night sweats | _____ Erectile dysfunction |
| _____ Lack of motivation | _____ Sleep disturbances | _____ Prostate problems |
| _____ Apathy | _____ Oily skin | _____ Increased urinary urge |
| _____ Depression | _____ Decreased stamina | _____ Infertility problems |
| _____ Irritability | _____ Aches and pains | _____ Decreased urine flow |
| _____ Morning fatigue | _____ Elevated triglycerides | _____ Blood sugar imbalance |
| _____ Evening fatigue | _____ Decreased muscle mass | _____ Cold body temperature |
| _____ General fatigue | _____ Bone loss | _____ Headaches |
| _____ Chronic illness | _____ Elevated cholesterol | _____ Susceptible to infections |
| _____ Autoimmune illness | _____ Decreased mental sharpness | _____ Fibromyalgia |
| _____ Other: please list _____ | | |

