

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? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. Do you have/had hypertension? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. Do you have heart disease? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4. Do you have a heart murmur? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 5. Do you have/had kidney disease? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 6. Have you ever been treated for psychiatric problems? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 7. Have you ever had rheumatic fever? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 8. Do you have mitral valve prolapse? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 9. Have you ever had a urinary tract infection? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 10. Have you ever had hepatitis/liver disease? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 11. Have you ever had varicosities/phlebitis? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 12. Do you have any thyroid problems? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 13. Have you had any major accidents? | <input type="checkbox"/> YES | <input type="checkbox"/> 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? _____

FAMILY HISTORY

1. Do you have a family history of breast cancer? YES NO
If yes, whom? _____
2. Do you have a family history of colon cancer? YES NO
If yes, whom? _____
3. Do you have a family history of ovarian cancer? YES NO
If yes, whom? _____
4. Do you have a family history of osteoporosis? YES NO
If yes, whom? _____
5. Do you have a family history of diabetes? YES NO
If yes, whom? _____
6. Do you have a family history of hypertension? YES NO
If yes, whom? _____
7. Do you have a family history of heart disease? YES NO
If yes, whom? _____
8. Do you have a family history of kidney disease? YES NO
If yes, whom? _____



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

MALE PROSTATE EXAM WAIVER
For
TESTOSTERONE PELLETT THERAPY

I, _____, voluntarily choose to undergo implantation of sub-dermal bio identical Testosterone pellet therapy. For today's appointment, I have not provided you with a prostate exam report due to:

- _____ My decision not to have a prostate exam
- OR
- _____ I am unable to provide at my consultation appointment.

I have voluntarily chosen to sign this release form. I agree that if any issues arise and/or develop while on pellet therapy, I release _____ from any liability.

Signed: _____

Date: _____