BHRT MALE PATIENT INFORMATION

NAME: _________________________________**DATE**_______________________

EMAIL ADDRESS: ____

PHONE NUMBER: CELL:_________________**HOME:**_____________________

DATE OF BIRTH ______/______/______ **AGE:** __________________________

HEIGHT____________ **WEIGHT** _____________ **BMI**_____________________

Who referred you to us? ____

Please list your health care provider information and the date of your last visit:

DOCTOR'S NAME: ________________________________ PHONE: ___________________________

Address: _____________________________________City:___________ State:______ Zip:_______

Date of Last Visit: _________________________

SOCIAL HISTORY

ALCOHOL: o **Y** o **N** How much per week? ______________
DO YOU SMOKE? o **Y** o **N** If yes, how many packs per day? ___________
DO YOU EXERCISE? o **Y** o **N** If yes, what type? _____________ How often? _________________
CAFFEINE CONSUMPTION o **Y** o **N** Type (coffee, soda) ___________ How much? _________
DESCRIBE YOUR DIET: ____
____
____

HEALTH SUMMARY FORM

Allergies to medication? o Y o N ___________________________________

Prescription or OTC Medication? o Y o N

Medication Name Date started
____
____
____
____

Hormones Previously Taken

(Synthetic, Bio-Identical and over-the-counter**)**

Date started Date stopped Reason
____
____
____

Current or Past Medical Conditions

(Please check all that apply)

o High Cholesterol
o High Blood Pressure
o Cancer (type: _______________)
o Asthma
o Blood Clotting Disorder
o Diabetes (type: ______________)
o Epilepsy
o Osteoporosis/Osteopenia
o Other: ______________________

o Heart Disease
o Thyroid Disorder
o Kidney Disorder
o Arthritis
o Liver Disorder
o Depression
o Headaches/Migraine
o Chronic Fatigue Syndrome

Family History: (Please check all that apply)

o Prostate Cancer - Family Member(s) ____
o Other Cancer - Family Member(s) ____
o Diabetes - Family Member(s) ____
o Heart Disease - Family Member(s) ____

Surgical History:

____
____
____

Date of last prostate exam____
Date of last testicular exam____

Why would you like to start Bio-Identical Hormone Replacement Therapy?

SYMPTOM SHEET
(Please check all that apply)

	Absent	Mild	Moderate	Severe
Fatigue	___________	__________	____________	__________
Decrease Muscle Mass	___________	__________	____________	__________
Loss of Muscle Strength	___________	__________	____________	__________
Joint or Muscle Pains	___________	__________	____________	__________
Increase Waist Size	___________	__________	____________	__________
Weight Gain	___________	__________	____________	__________
Decrease Sex Drive	___________	__________	____________	__________
Decrease Full Erections	___________	__________	____________	__________
Decrease Morning Erections	___________	__________	____________	__________
Irritability	___________	__________	____________	__________
Decrease Memory	___________	__________	____________	__________
Poor Concentration	___________	__________	____________	__________
Depression	___________	__________	____________	__________
Sleep Disturbances/Insomnia	___________	__________	____________	__________
Decrease Interest in Hobbies	___________	__________	____________	__________
Decrease Personal Interests	___________	__________	____________	__________
Night-time Urination	___________	__________	____________	__________
Moodiness	___________	__________	____________	__________
Hair Loss	___________	__________	____________	__________