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Date_____

Male Patient Information and Health Summary

Name_____ Date of Birth _____

Address_____City/State/ZIP_____

Home Phone (_____)-_____-_____ Cell Phone (_____)-_____-_____

Who referred you to us? _____

Please List Your Healthcare Providers & Indicate Which Doctor to Contact Regarding Hormone Therapy

Name_____	Name_____
Specialty _____	Specialty_____
Location _____	Location_____
Phone _____	Phone_____
Fax_____	Fax_____

Insurance Information:

Plan Name _____ BIN# _____PCN# _____

ID# _____ Pharmacy Group# _____

Who is the main cardholder? _____ Your member# _____

Any Known Medication Allergies?

_____

Please List Any Medications You Are **Currently** Taking, Including Vitamins, Natural Supplements, or Non-Prescription Medications: _____

_____

_____

Is your **Diet:** 1 Bad 2 Fair 3 Good 4 Very Good (please circle)

Exercise: type of activity, how frequent, and for how long?

_____

Employer and Job Title _____

Circle your perceived stress level: 1 None 2 Mild 3 Moderate 4 Severe 5 Extremely Severe

Family History

Please check all that apply:

___ Cancer (type)

___ Breast_____ Relationship to you_____

___ Uterine_____ Relationship to you_____

___ Ovarian_____ Relationship to you_____

___ Other_____ Relationship to you_____

___ Diabetes; type_____ Relationship to you _____

___ Heart Disease_____ Relationship to you_____

___ Osteoporosis_____ Relationship to you _____

___ Alzheimer's Disease_____ Relationship to you_____

___ Thyroid Disease_____ Relationship to you_____

Past or Present Medical Conditions

Please check all that apply:

___ Asthma	___ Fibromyalgia	___ Fractures _____
___ Cancer (type:_____	___ Arthritis	___ Epilepsy
___ Depression	___ Varicose Veins	___ Liver Disorder
___ Diabetes (type:_____)	___ Kidney Disorder	___ Eating Disorder
___ Headaches/Migraines	___ Thyroid Disorder	___ Ulcers
___ Heart Condition _____	___ High Cholesterol	___ Chronic Fatigue Syndrome
___ High Blood Pressure	___ Clotting Disorder	___ Other _____
___ Osteoporosis/Osteopenia	___ Gallbladder Disease	

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Have you ever had . . . (check all that apply)

___ Difficulty Achieving Erection	___ Lack of Sex Drive	___ Painful Intercourse
___Lack of Energy	___Genital warts	___ Inability to reach climax

Previous hormone therapies…

Have you ever taken hormones before? ___Yes ___No

If so, please list **previous and current** hormones taken, **doses**, and any side effects here:

_____

_____

Have you tried alternative therapies or taken any herbal or homeopathic products?

_____

_____

How did you become interested in bio-identical hormones?

_____

_____

Please check all symptoms below that apply (this is very important to the evaluation process)

Symptoms of **low Progesterone**?

__ Acne
__ Anxiety/Irritability
__ Weight Gain
__ Mood Swings
__ Food Cravings
__ Joint Pain
__ Headaches
___per week
__ Low Sex Drive
__ Depression
__ Fuzzy Thinking
__ Low Energy

Other symptoms?

__ Insomnia

Symptoms of **low Testosterone?**

__ Depression
__ Joint Pain
__ Heart Palpitations
__ Fibromyalgia
__ Urinary Incontinence
__ Low Sex Drive
__ Memory Lapses
__ Thinning Skin
__ Low Energy
__ Bone Loss
__ Muscle Weakness

Other Symptoms_____

Top 3 symptoms you'd like resolved: _____

Circle the number that best describes the DEGREE of symptom intensity you have experienced over the past month(s)

	None 0	Mild 1	Moderate 2	Severe 3
1. Insomnia or restless, fragmented sleep?				
	0	1	2	3
2. Irritability, feeling anxious or apprehensive?				
	0	1	2	3
3. Feeling of depression and unhappiness and/or being miserable without obvious reason?				
	0	1	2	3
4. Sensations of dizziness or swimming in the head?				
	0	1	2	3
5. Feeling of weariness of mind and body with desire for rest; disinclination to make further efforts?				
	0	1	2	3
6. Pain of any kind affecting joints or muscles?				
	0	1	2	3
7. Headaches of any kind (tension, migraine, etc.)?				
	0	1	2	3
8. Quickening or acceleration of heartbeat or fluttering/pounding heartbeat in a sitting or resting position?				
	0	1	2	3

Have you ever had . . .

Never	Infrequently	Sometimes	Most of Time	Always
0	**1**	**2**	**3**	**4**

1. Painful urination or increased frequency or urination?

0 1 2 3 4

2. Leaking of urine when coughing, laughing, sneezing, or on hard work?

0 1 2 3 4

3. Leaking of urine when walking, running, climbing steps, or on light work?

0 1 2 3 4

4. Leaking of urine, regardless of activity, even when in a lying position?

0 1 2 3 4