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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:

<input type="checkbox"/> Cancer (type)	
<input type="checkbox"/> Breast _____	Relationship to you _____
<input type="checkbox"/> Uterine _____	Relationship to you _____
<input type="checkbox"/> Ovarian _____	Relationship to you _____
<input type="checkbox"/> Other _____	Relationship to you _____
<input type="checkbox"/> Diabetes; type _____	Relationship to you _____
<input type="checkbox"/> Heart Disease _____	Relationship to you _____
<input type="checkbox"/> Osteoporosis _____	Relationship to you _____
<input type="checkbox"/> Alzheimer's Disease _____	Relationship to you _____
<input type="checkbox"/> Thyroid Disease _____	Relationship to you _____

Past or Present Medical Conditions

Please check all that apply:

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

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

<input type="checkbox"/> Difficulty Achieving Erection	<input type="checkbox"/> Lack of Sex Drive	<input type="checkbox"/> Painful Intercourse
<input type="checkbox"/> Lack of Energy	<input type="checkbox"/> Genital warts	<input type="checkbox"/> 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