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BHRT Symptom Update--Male

Date_____

Name_____ Date of Birth _____

Address_____

Home Phone (____)_____ Cell Phone (____)_____

Have there been any changes in any of your medications in the past year? If so, please list:

_____

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

Symptoms of **low Progesterone**?

__ Food Cravings
__Anxiety/Irritability
__Joint Pain
__Low Energy
__Weight Gain
__Mood Swings
__ Headaches
_____x per week
__ Fuzzy Thinking
__ Acne
__ Low Sex Drive
__ Depression

Other Symptoms?

__ Insomnia _____x per week
__ Dry Skin

Symptoms of **low Testosterone?**

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

Have any symptoms become more frequent/bothersome in the past few months?_____

_____

_____

_____

_____

Filling out a Symptom Update Sheet gives the pharmacist permission to make dosing change suggestions to your doctor. If you do not want changes, there is no reason to fill out the sheet. If you do not want the new changes filled right away, but put "On Hold" for the next time you need them filled, please check this box. ☐