Men's Hormone Therapy History Form

Date: _____

Patient name _____ Date of 8irth:_____ Phone_____

Address _____

Blood pressure _____ Ht:____ Wt:____ BM! ____

History of blood clots or heart disease _____

Any changes in health history? _____

Have you or a family member had the following:

Prostate Cancer_____ Who? _____ Prostatitis? _____ Who? _____

Cancer of any kind? _____ Who? _____ What type_____

Past Medical History:

Do you smoke? _____ If so, how much? _____

Have you ever used Testosterone Replacement? _____ If so, when?_____

Are you needing to preserve fertility in order to have more children? _____

Colonoscopy (date/result)_____ PSA (date/result)_____

Primary care Physician _____

Circle Which Symptoms You Are Experiencing at Present:

Energy (Good/Fair/Poor)

Appetite (Good/Fair/Poor)

Sleep (Good/Fair/Poor)

Libido (sex drive) Decreased/Increased

Joint Complaints

Hot flashes

Loss of Muscle

Fatigue

Poor cognitive function

BPH/frequent urination

Depression/Anxiety

Moodiness

Medications and Over-the-Counter Supplements _____

4784 S. Lee Hwy, McDonald, TN, 37353 | 423-299-3046 | dana@hormonallyrooted.com