MALE HEALTH EVALUATION

DATE: _____

Name: _____**Birth Date**: _____**Age**_____

Address: _____

City: _____**State:** _____**Zip Code**: _____

Cell Phone: _____

Home Phone: _____

Email Address: _____

Primary Care Physician:

Name: _____

Address: _____

Phone: _____

Physician Specialist we need to collaborate with regarding your therapy:

Name: _____Specialty: _____

Address: _____

Phone: _____

Name: _____Specialty: _____

Address: _____

Phone: _____

Name: _____Specialty: _____

Address: _____

Phone: _____

MALE HEALTH EVALUATION

Medical History:

Allergies: Please list all that apply with reaction.

Drugs: _____

Foods: _____

Other: _____

Medications: (include OTC antacid, pain reliever, acid blocker, laxative, decongestant, cough suppressant, anti-diarrheal, sleep aid and any Prescribed medications)

	Name	Dose	Route	How Often
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

Nutritional/Natural Supplements:

1. Vitamins (ex. multiple or singles, such as B complex, E, C, D)
   _____
2. Minerals (ex. Calcium, magnesium, chromium)
   _____
3. Herbs (ex. Ginseng, gingko biloba, etc.)
   _____
4. Enzymes (ex. digestive formulas, papaya, bromelain, Coenzyme Q10, etc.)
   _____
5. Nutrition/protein supplements (ex. Shark cartilage, protein powders, amino acids, fish oils, etc.)
   _____

Current Hormone Therapies:

Name	Strength	Date started	How often per day

MALE HEALTH EVALUATION

List Hormones previously taken:

Name	Date started	Date stopped	Reason stopped
_____			
_____			
_____			

Medical Diseases: Check all that apply to you.

___Heart disease
___Ulcers
___Blood clotting problems
___Epilepsy
___Chronic Fatigue Syndrome
___Parkinson's Disease
___High cholesterol
___Thyroid disease
___Diabetes
___Headaches/Migraines
___Lyme Disease
___Irritable Bowel Syndrome
___High Blood Pressure
___Hormonal related issues
___Arthritis or joint problems
___Eye disease
___Schizophrenia
___Traumatic Brain Injury
___Cancer
___Lung Condition
___Depression
___Bipolar Disease
___Infection: explain type and treatment
_____
Other:
_____

Have you had any of the following tests performed?

____PSA test Date: _____ Results: _____
____Colonoscopy Date: _____ Results: _____

Surgical History:

	Type	Date/Year
1.	_____	
2.	_____	
3.	_____	
4.	_____	
5.	_____	
6.	_____	
7.	_____	
8.	_____	

Social History:

Do you use tobacco? ____yes ____no; If yes, How much and how often? _____
Do you use alcohol? ____yes ____no; If yes, How much and how often? _____
Do you use caffeine? ____yes ____no; If yes, How much and how often? _____

MALE HEALTH EVALUATION

Family History:

Do you have a family history of any of the following?

1. ___Heart Disease Family member (s)_____
2. ___Cancer Family member (s) _____
   Type of Cancer (s) _____
3. ___Diabetes Family member (s)_____

Stress Reducers:

1. Do you practice Yoga/Meditation/Tai Chi/Diaphragmatic Breathing/Bio-feedback? YES/NO
2. If yes, which one and how often? _____
3. Do you exercise? YES/NO
4. If yes, what type and how often? _____
5. How many ounces of water intake/day do you consume? _____

Diet: Please Complete the 3-day Diet Log prior to coming to your consultation

Height:_____Weight: _____BMI: _____Goal Weight: _____

SYMPTOM SURVEY

Instructions: Please enter the appropriate response number to each question in the columns below

0 = None/Absent 1 = Mild or Rare 2 = Moderate 3 = Severe

Add an * (asterisk) if symptom is intermittent or "Come and goes"

1. _____Erectile dysfunction
2. _____Hair loss
3. _____Low libido
4. _____Fatigue
5. _____Night sweats/hot flashes
6. _____Memory loss
7. _____Mood swings/irritability
8. _____Heart palpitations
9. _____Muscle loss/weakness
10. _____Sleep apnea/insomnia
11. _____Depression
12. _____Anxiety
13. _____Constipation
14. _____Loose Stools
15. _____Gynecomastia (development of breasts in men

How old are you? _____

How old do you feel? _____

MALE HEALTH EVALUATION

Goals:

1. How did you arrive at the decision to consider Bio-Identical Hormone Replacement Therapy (BHRT)?
   ____Doctor
   ____Self
   ____Friend
   ____Family Member
   ____Internet
   ____Other: _____

2. What are your goals with Bioidentical Hormone Replacement Therapy (BHRT) and Treatment?
   _____
   _____
   _____
   _____
   _____

3. What Questions do you have about BHRT that we can address at your visit?
   _____
   _____
   _____
   _____
   _____
   _____
   _____

DISCLAIMER: By signing this form, I authorize the release of my medical information to share with other healthcare professional for treatment purposes only.

Patient's Signature Date

MALE HEALTH EVALUATION

THYROID EVALUATION

SYMPTOMS	ABSENT	MILD	MODERATE	SEVERE
Depression				
Weight Gain				
Cold extremities				
Cold Intolerance				
Feel Chilly				
Dry Hair				
Eczema				
Acne				
Puffy Eyelids/Face				
Brittle Nails				
Difficult Menses				
Constipation				
Mentally Sluggish				
Headache				
Insomnia				
Early Morning Fatigue				
Late Morning Fatigue				
Evening Fatigue				
Muscle Cramps				
Low Sex Drive				

Please check which box most correctly describes your symptoms.

1. When did the symptoms start?

   _____

2. Is there a family history of ANY thyroid disease? Please list whom and what type (goiter hypothyroidism, Graves' Disease, Hashimoto's Disease)

   _____

   _____

3. Have you ever been tested for thyroid problems? If yes, please list doctor, when diagnosed, and any therapy given.

   _____

   _____

4. Do you have any current thyroid lab results such as: TSH, Free T4, Free T3, Reverse T3, Lipid panel, Hemoglobin, ferritin, etc.? Please provide documentation if available.
   Yes_____No_____
5. Have you had any other additional thyroid test performed (Urine Iodine Challenge, etc)?

   _____

MALE HEALTH EVALUATION

ADRENAL EVALUATION

Instructions: Please enter the appropriate response number to each question in the columns below.

0 = Never/Rarely
1 = Occasionally/slightly
2 = Moderate in Intensity or Frequency
3 = Intense/Severe or Frequent
(ranking your symptoms this way is important to our assessment)

I have not felt well since (Date) _____

When (Describe a specific event, if any) _____

Predisposing Factors

Past	Now	
		1. I have experienced long periods of stress that have affected my well being
		2. I have had one or more severely stressful events that have affected my well being
		3. I have driven myself to exhaustion
		4. I overwork with little play or relaxation for extended periods
		5. I have had extended, severe or recurring respiratory infections
		6. I have taken long term or intense steroid therapy
		7. I tend to gain weight, especially around the middle (spare tire)
		8. I have a history of alcoholism &/or drug abuse
		9. I have environmental sensitivities
		10. I have diabetes (type II, adult onset, NIDDM)
		11. I suffer from post-traumatic distress syndrome
		12. I suffer from anorexia
		13. I have one or more other chronic illnesses or diseases

Energy Patterns

Past	Now	
		1. I often have to force myself in order to keep going. Everything seems like a chore
		2. I am easily fatigued
		3. I have difficulty getting up in the morning (don't really wake up until about 10 AM)
		4. I suddenly run out of energy
		5. I usually feel much better and fully awake after the noon meal
		6. I often have an afternoon low between 3:00-5:00 PM
		7. I get low energy, moody or foggy if I do not eat regularly
		8. I usually feel my best after 6:00 PM
		9. I am often tired at 9:00 -10:00 PM, but resist going to bed
		10. I like to sleep late in the morning
		11. My best, most refreshing sleep often comes between 7:00-9:00 AM
		12. I often do my best work late at night or (very early in the morning)
		13. If I don't go to bed by 11:00 PM, I get a second burst of energy which often last until 1:00-2:00 AM