



Male Bio-Identical Hormone Replacement Questionnaire

Personal Data			
Name:		Date:	
Address:	City:	State:	Zip:
Home phone:	Cell phone:	Work phone:	
Date of Birth:		Age:	
E-mail Address:			
Primary Care Physician			
Name:		Phone:	
Address:	City:	State:	Zip:

Present Symptoms
Please briefly describe your symptoms.
What do you feel is the most important factor to your present symptoms?

Past Medical History	
Date	Medical diagnosis, illness, accident

Past Surgical History	
Date	Surgery

Medications		
Please list ALL prescription medications. Include ALL over the counter medications, supplements, and vitamins.		
Name of Medication	Dosage	Dosing schedule

Allergies
Are you allergic to ANY MEDICATIONS (prescription or over the counter)?

Please list ALL illnesses (heart disease, stroke, diabetes, hypertension, cancer (breast, cervical, prostate, lung, skin, blood, etc...)). If a member is deceased please list age at death and cause of death if known.		
Relationship	Age	Medical problem/ Cause of death
Mother		
Father		
Brothers		
Sisters		
Children		
Spouse		

Social History
Please remember this information is strictly confidential and will be used only to address your symptoms and/or complaints.
<p>Do you smoke cigarettes now or have you in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <ul style="list-style-type: none"> • If yes, how many packs per day? _____ • How many total years have you smoked? _____
<p>Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <ul style="list-style-type: none"> • If yes, how many drinks and what kind (wine, beer, bourbon, etc.)do you have in an average week? _____.
<p>Do you now or have you in the past used any illicit drugs (marijuana, amphetamines, narcotics, psychedelics, cocaine, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <ul style="list-style-type: none"> • If yes, what substance and how often? _____

Genitourinary History		
	YES	NO
Have you ever had a rectal exam? If yes, what was the result? _____		
Have you ever had any surgery, biopsy, and/or trauma to your penis, testicles, or prostate?		
Have you ever had or have infections or discharge of the above areas? If yes, please explain treatment. _____		
Have you ever had any problems starting a stream of urine or ending to urinate? If so, have you received any therapy? _____		
Have you ever had any reason to suspect that you may have prostate or testicular cancer? If so, please explain. _____		
Would you like to improve your sexual intimacy with your partner? If yes, please describe. _____		
On the average, how often do you have sexual intercourse per week?		

Hormone Therapy History				
Have you been treated with hormone replacement therapy? If yes, please give approximate periods of treatment:				
Hormone	Dose	Reason	Start Date	Stop Date

Estrogen Excess	
Check which of these symptoms are troublesome and have persisted over time	
<input type="checkbox"/> Enlarged prostate	<input type="checkbox"/> Weight gain
<input type="checkbox"/> Prostate cancer	<input type="checkbox"/> Low sex drive
<input type="checkbox"/> Testicular cancer	<input type="checkbox"/> Coronary Artery Disease
<input type="checkbox"/> Breast development, "man boobs"	
<input type="checkbox"/> Impotency	
<input type="checkbox"/> Male pattern baldness	

DHEA	
Check which of these symptoms are troublesome and have persisted over time	
<input type="checkbox"/> My Hair is dry	
<input type="checkbox"/> I don't have much fatty tissue in the pubic area	
<input type="checkbox"/> My eyes and skin are dry	
<input type="checkbox"/> My body doesn't have much of a special scent during sex	
<input type="checkbox"/> My muscles are flabby	
<input type="checkbox"/> I can't tolerate noise	
<input type="checkbox"/> My belly is getting fat	
<input type="checkbox"/> My libido is low	
<input type="checkbox"/> I don't have much hair under my arm	
<input type="checkbox"/> I don't have much hair in my pubic area	

Growth Hormone	
Check which of these symptoms are troublesome and have persisted over time	
<input type="checkbox"/> I often feel unwell	<input type="checkbox"/> I feel I am rapidly aging
<input type="checkbox"/> I get easily exhausted	<input type="checkbox"/> I am a light sleeper
<input type="checkbox"/> I feel lack of inner peace	<input type="checkbox"/> I excessively need at least 9 hours of sleep
<input type="checkbox"/> I have difficulty recovering when going to bed late	
<input type="checkbox"/> I feel chronically anxious	
<input type="checkbox"/> I often get a feeling of collapsing	
<input type="checkbox"/> I have a tendency to be depressed	
<input type="checkbox"/> I feel a lack of self control	
<input type="checkbox"/> I have outbursts of panic/anxiety	

Pregnenolone Deficiency	
Check which of these symptoms are troublesome and have persisted over time	
<input type="checkbox"/> I have memory loss	
<input type="checkbox"/> My joints hurt (fingers, wrists, elbows, ankles, knees)	
<input type="checkbox"/> I'm feeling a bit drained and it's hard to handle stress	
<input type="checkbox"/> I don't see colors as brightly as before	
<input type="checkbox"/> I have lost interest/ appreciation for art	
<input type="checkbox"/> I don't have much hair under my arms or pubic area	
<input type="checkbox"/> I feel more tired at rest than when I am active	
<input type="checkbox"/> I have abundant, light-colored urine during the day	
<input type="checkbox"/> I have low blood pressure	
<input type="checkbox"/> I crave salty foods	

Adrenals		
Check which of these symptoms are troublesome and have persisted overtime.		
<input type="checkbox"/> Sleep Disturbances <input type="checkbox"/> Bone Loss <input type="checkbox"/> Fatigue <input type="checkbox"/> Weight Gain- Waist <input type="checkbox"/> Loss of Muscle Mass <input type="checkbox"/> Thinning Skin <input type="checkbox"/> Elevated Triglycerides <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Irritable <input type="checkbox"/> Anxious <input type="checkbox"/> Memory	<input type="checkbox"/> Heart Palpitations <input type="checkbox"/> Headaches <input type="checkbox"/> Stress <input type="checkbox"/> Cold Body Temperature <input type="checkbox"/> Sugar Cravings <input type="checkbox"/> Low Libido <input type="checkbox"/> Hair Loss <input type="checkbox"/> Increased Facial Hair <input type="checkbox"/> Increased Body Hair <input type="checkbox"/> Acne <input type="checkbox"/> Nervous	<input type="checkbox"/> Fatigue Early During the Day <input type="checkbox"/> Sugar Cravings <input type="checkbox"/> Allergies <input type="checkbox"/> Chemical Sensitivity <input type="checkbox"/> Handle Stress Poorly <input type="checkbox"/> Cold Body Temperature <input type="checkbox"/> Irritable/ Angry <input type="checkbox"/> Arthritis <input type="checkbox"/> Heart Palpitations <input type="checkbox"/> Aches/ Pains <input type="checkbox"/> Repeated Illnesses

Thyroid	
Check which of these symptoms are troublesome and have persisted over time.	
Thyroid Excess	Thyroid Deficiency
<input type="checkbox"/> Heat Intolerance <input type="checkbox"/> Voice has become hoarse <input type="checkbox"/> Palpitations <input type="checkbox"/> Weight Loss <input type="checkbox"/> Tremors/ Shakiness <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nervousness/ Anxious/ Panic Attacks <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Difficulty Conceiving/ Infertility <input type="checkbox"/> Coarse, Dry Skin <input type="checkbox"/> Insomnia	<input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Constipation <input type="checkbox"/> Fatigued/ Weakness <input type="checkbox"/> Unexplained Weight Gain <input type="checkbox"/> Inability to Lose Weight <input type="checkbox"/> Stressed <input type="checkbox"/> Cold Body Temperature <input type="checkbox"/> Irritable <input type="checkbox"/> Lack of Motivation <input type="checkbox"/> Muscle Cramps <input type="checkbox"/> Aches/ Pains

Androgen Deficiency	
Check which of these symptoms are troublesome and have persisted over time	
<input type="checkbox"/> Decreased Libido	<input type="checkbox"/> Malaise- Lack of drive or energy
<input type="checkbox"/> Diminished sexual ability	<input type="checkbox"/> Decrease in competitiveness
<input type="checkbox"/> Harder to achieve or maintain an erection	<input type="checkbox"/> Bone loss (Osteoporosis)
<input type="checkbox"/> Fatigued or have a lack of energy	<input type="checkbox"/> Increased urinary urgency
<input type="checkbox"/> Decrease in strength and/or endurance	<input type="checkbox"/> Prostate problems
<input type="checkbox"/> Loss of muscle and muscle mass	<input type="checkbox"/> Decreased mental sharpness
<input type="checkbox"/> Increased abdominal fat or developed "man boobs"	<input type="checkbox"/> Depression
<input type="checkbox"/> Recent deterioration in your work or performance	<input type="checkbox"/> Sleep disturbances
<input type="checkbox"/> Memory Lapses- Forgetfulness	
<input type="checkbox"/> Recent deterioration in your ability to play sports	
<input type="checkbox"/> History of high cholesterol or elevated blood sugar	

System Review - Check the appropriate box for each question.			
Constitutional/ ID/ Oncology	Yes	No	Not Sure
Have you had unexplained weight loss?			
Do you have a hard time waking up in the morning?			
Do you often feel tired in the afternoon?			
Do you have any bone disorder problems?			
Do you have fever or chills?			
Do you have night sweats?			
Do you notice swollen lymph nodes?			
Have you ever been diagnosed with cancer?			
Have you ever tested positive for HIV?			
Have you ever had a sexually transmitted disease?			
Respiratory			
Do you have a cough?			
Do you frequently sneeze?			
Do you have excessive daytime sleepiness?			
Do you snore?			
Have you ever been diagnosed with asthma or emphysema?			

System Review – Check the appropriate box for each question.			
	Yes	No	Not sure
Do you have chest pains?			
Do you have palpitations?			
Do you have shortness of breath?			
Do you have swelling in your legs?			
Do you have leg pain while walking?			
Have you been diagnosed with any heart condition?			
Have you ever been diagnosed with a blood clot?			
Gastrointestinal			
Do you have trouble swallowing food?			
Do you have nausea or vomiting			
Do you have diarrhea?			
Do you have blood in your stool?			
Do you have abdominal pain or bloating?			
Have you ever been diagnosed with hepatitis or liver disease?			
Endocrine			
Do you urinate frequently or in larger amounts than usual?			
Do you have a greater than normal urge to eat?			
Are you excessively thirsty?			
Do you have facial hair?			
Do you have acne?			
Have you ever been diagnosed with a thyroid problem?			
Neurological			
Do you have muscle weakness?			
Have you ever had a seizure?			
Have you ever fainted?			
Have you ever experienced double vision or blind spots?			
Have you ever been diagnosed with a stroke?			
Urologic / Renal			
Do you have burning when you urinate?			
Do you have urgency when you urinate?			
Do you urinate more frequently than others?			
Do you leak urine when laughing or coughing?			
Have you ever had any kidney problems?			

Physician Notes: