MALE PATIENT INFORMATION

BIO-IDENTICAL HORMONE REPLACEMENT THERAPY (BHRT)

Date:____________________

Name: ____
Last First Middle

Date of birth:_________________(MM/DD/YYYY) SS#:_______-_____-_______

Street Address:____

City, State, Zip:____

Reliable Phone Number:____

E-mail:____

Employer:____

Employer Street Address:____

Employer City, State, Zip:____

Business Phone Number:____

Marital Status (circle): Married Divorced Single Widow Living with Partner

Spouse/Partner Name:____

Spouse/Partner Phone Number:____

In Case of Emergency Please Contact:____

Relationship:______________________________Contact Phone Number:_______________________

Signature:____Date:____________________

Louisville Lifestyle Medicine

3012 Eastpoint Parkway Louisville KY 40223

502.365.4545 P 502.365.4546 F www.louisvillelifestylemedicine.com

Please describe you symptoms and reason for appointment:

____
____
____
____
____
____
____
____

What are you hoping to improve in your lifestyle:

____
____
____
____
____

How did you hear about us?____
____
____

SYMPTOMS

Are you suffering from any of the following:

Fatigue?	YES	NO
Decrease of Memory?	YES	NO
Decrease in Energy Level?	YES	NO
Decrease in Sexual Desire?	YES	NO
Anxiety?	YES	NO
Irritability?	YES	NO
Depression?	YES	NO

Mood Swings? YES NO

Migraines/Headaches? YES NO

Memory Loss? YES NO

Decrease is muscle? YES NO

Unclear Thinking? YES NO

How have you dealt with the above symptoms?__________________________________
____
____
____
____

Is your sex drive similar as it was five years ago? YES NO

Do you have any sexual dysfunction? YES NO

Have you experienced weight gain in the last 1-2 years? YES NO
If yes, please explain____

Have you lost more than 10 pounds in less than a month? YES NO
If yes, please explain____

Are you HIV positive? YES NO

Do you have biological children? YES (How many?______) NO

Have you had your testosterone level determined in the past? YES NO
If yes, why?____

Sexual Orientation? (circle) Heterosexual Homosexual Bisexual

SOCIAL/WELLNESS HISTORY

Do you smoke cigarettes? YES NO USED TO

If yes, please indicate the number of cigarettes you smoke(d) per day on average: ________

Please list the number of years you have/had been smoking:_________years

Do you use recreational drugs? YES NO

Do you drink alcohol? YES NO

If yes, what type of alcohol do you drink?_____________________________________

How many drinks per week, on average, do you drink?______________________________

Are you using any form of Testosterone or Hormone Therapy? YES NO

If yes, please circle which type:

Gel Cream Shots Pellets Other

How many hours of sleep do you get a night?____________hours

How often does your sleep during the night get interrupted:

Never Rarely Often Can't Keep Count

MEDICAL HISTORY

Do you have diabetes? YES NO

Do you have or have you ever had hypertension? YES NO

Do you have heart disease? YES NO

Have you ever had a heart attack? YES NO

Have you ever had a stroke? YES NO

Do you have a heart murmur? YES NO

Do you have or have you ever had kidney disease? YES NO

Have you ever been treated for a psychiatric disorder? YES NO

If yes, please name the disorder:____________________________________

Have you ever had rheumatic fever? YES NO

Do you have mitral valve prolapse? YES NO

Have you ever had a urinary tract infection? YES NO

Have you ever had hepatitis? YES NO

If yes, please circle which type:

Hepatitis A Hepatitis B Hepatitis C Other

Have you ever had liver disease? YES NO

Have you ever had varicose veins? YES NO

Have you ever had phlebitis? YES NO

Do you have any thyroid problems? YES NO

If yes, please circle the symptoms:

Low Function Overactive Goiter Hashimoto's

Have you ever had a blood transfusion? YES NO

Do you have asthma, emphysema or chronic bronchitis? YES NO

Do you have or have you ever had leukemia? YES NO

If yes, are you currently undergoing any treatment? YES NO

Please circle the type of treatment: Surgery Radiation

Do you have or have you ever had lymphoma? YES NO

If yes, are you currently undergoing any treatment? YES NO

Please circle the type of treatment? Surgery Radiation

Do you have or have you ever had colon cancer? YES NO

If yes, are you currently undergoing any treatment? YES NO

Please circle the type of treatment: Surgery Radiation

Do you have or have you ever had colon polyps? YES NO

If yes, are you currently undergoing any treatment? YES NO

Do you have or have you ever had multiple myeloma? YES NO

If yes, are you currently undergoing any treatment? YES NO

Do you have or have you ever had lung cancer? YES NO

If yes, are you currently undergoing any treatment? YES NO

Do you have or have you ever had rectal cancer? YES NO

If yes, are you currently undergoing any treatment? YES NO

Please circle the type of treatment: Surgery Radiation

Do you have any drug allergies? YES NO

If yes, please list the drugs you are allergic to:___________________________________
____
____

Please list all major surgeries/hospitalizations (including year and reason):
____
____
____
____
____

Have you ever had any anesthesia complications? YES NO
If yes, please explain:____
____
____

Are you currently or have you ever been anemic? YES NO

Have you had any blood problems? YES NO

Do you have a Family Physician? YES NO

Please list the name of the physician and a number where they may be reached:

Physician Name:____

Phone Number:____

Are you currently taking any medications? YES NO

Please list the medications and dosage you are currently taking:

____

____

____

Have you ever had your cholesterol checked? YES NO

If yes, what was the date it was last checked:__________________________________

How was your cholesterol? Low Normal High

Do you have arthritis? YES NO

If yes, what type:____

Do you have lupus? YES NO

Do you have scleroderma? YES NO

Do you have arthritis? YES NO

Have you had blood clots in your legs or lungs? YES NO

Have you had any major accidents? YES NO

If yes, explain:____

Do you have osteopenia? YES NO

If yes, how was it treated:____

____

Do you have osteoporosis? YES NO

If yes, how was it treated:____

____

Do you suffer from hair loss? YES NO

Do you suffer from acne or have you? YES NO

FAMILY HISTORY

Do you have a family history of breast cancer? YES NO

If yes, what family member(s)?____

Do you have a family history of colon cancer? YES NO

If yes, what family member(s)?____

Do you have a family history of osteoporosis? YES NO

If yes, what family member(s)?____

Do you have a family history of diabetes? YES NO

If yes, what family member(s)?____

Do you have a family history of hypertension? YES NO

If yes, what family member(s)?____

Do you have a family history of heart disease? YES NO

If yes, what family members?____

Do you have a family history of kidney disease? YES NO

If yes, what family member(s)?____