Hormone Replacement Therapy Medical History – Male

Date: ____/____/_____

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (Home) _____ (Cell) _____

Primary Care Physician: _____

I. Past Medical History:

High Blood Pressure:	Yes	○	No	○
Heart Disease:	Yes	○	No	○
High Cholesterol:	Yes	○	No	○
Diabetes:	Yes	○	No	○
Stroke:	Yes	○	No	○
Blood clots of Clotting Disorders:	Yes	○	No	○
Bleeding Disorders:	Yes	○	No	○
Depression / Anxiety:	Yes	○	No	○
Elevated PSA:	Yes	○	No	○
Enlarged Prostate (BPH):	Yes	○	No	○
Thyroid Problems:	Yes	○	No	○
Migraines:	Yes	○	No	○
Hepatitis or Liver Disease:	Yes	○	No	○
Rheumatoid Arthritis:	Yes	○	No	○
Prostate Cancer:	Yes	○	No	○
Bone Loss (Osteopenia or Osteoporosis):	Yes	○	No	○
Cancer:	Yes	○	No	○
Kidney Disease:	Yes	○	No	○
Immune Disorder:	Yes	○	No	○

Please list any additional medical history in the space below:

_____
_____
_____

II. Past Surgical History:

1. _____ Date of Surgery: _____
2. _____ Date of Surgery: _____
3. _____ Date of Surgery: _____
4. _____ Date of Surgery: _____
5. _____ Date of Surgery: _____

III. Current Medications (Prescribed and OTC), dose and frequency:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

IV. Allergies: (medication, food, etc…)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

V. Social History

Occupation: _____ **Ethnic Background:** _____

Diet: Regular ___ Vegetarian ____ Diabetic ____ Lo w Carb ____ Other _____

Hours Exercise per Week: 1 – 2 2 – 3 3 – 4 4 – 5 > 5

What Types? _____

Have you ever broken any bones? Yes ___ No ___ If yes, explain: _____

Do you smoke? Yes ____ No ____ If yes, how much? _____

Do you drink alcohol? Yes ____ No ____ if yes, how much? _____

VI: Family History:

Illness	**Relationship**
o Heart Disease:	_____
o Prostate Cancer	_____

- Colon Cancer _____
- Malignant Melanoma _____
- Osteoporosis _____
- Diabetes _____
- Alzheimer's Disease _____

VII: Symptoms

Forgetfulness:	Yes ○	No ○
Inability to Concentrate:	Yes ○	No ○
Memory Loss:	Yes ○	No ○
Depression:	Yes ○	No ○
Heart Palpitations:	Yes ○	No ○
Irritability:	Yes ○	No ○
Insomnia:	Yes ○	No ○
Panic Attacks:	Yes ○	No ○
Worry Needlessly:	Yes ○	No ○
Height Loss:	Yes ○	No ○
Fatigue:	Yes ○	No ○
Joint Pain:	Yes ○	No ○
Urinary Frequency	Yes ○	No ○
Nocturia:	Yes ○	No ○
Slow Urine Stream:	Yes ○	No ○
Decreased Sex Drive:	Yes ○	No ○
Erectile Dysfunction:	Yes ○	No ○
Decreased Morning Erections:	Yes ○	No ○
Dry Skin:	Yes ○	No ○
Decreased Male Performance:	Yes ○	No ○
Decreased Endurance:	Yes ○	No ○
Cold Hands/Feet:	Yes ○	No ○

Mood Swings:	Yes	○	No	○
Decreased Strength:	Yes	○	No	○
Weight Gain:	Yes	○	No	○
Loss of interest:	Yes	○	No	○