MALE HORMONE QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential.

CONTACT & PERSONAL INFORMATION

Please review our policies on making recommendations in the "Getting Started" section located in the Resources tab on our website.

Name: Date of Birth: MM DD YYYY

Address: City/Town:

State/Province: ZIP/Postal Code:

Email Address: Height (in): Weight (lbs):

PHONE NUMBER(s)

Home: Mobile:

ALLERGIES TO MEDICATIONS OR FOODS (DRUG/FOOD NAME & REACTION EXPERIENCED)

INSURANCE INFORMATION

Insurance Company: Insurance ID#:

Rx Group #: Rx Bin #: Rx PCN:

Doctor's Name: Doctor's Phone:

WHAT ARE YOUR MAIN REASONS FOR SEEKING CARE?

ARE YOU TAKING HORMONES? IF SO WHAT IS YOUR REGIMEN?

LIST ANY PREVIOUS HORMONE THERAPY YOU HAVE TRIED

LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS, NUTRITIONAL OR NATURAL PRODUCTS YOU ARE CURRENTLY TAKING

SURGERY AND MEDICAL HISTORY

All questions contained in this questionnaire are optional and will be kept strictly confidential.

HAVE YOU HAD ANY OF THE FOLLOWING SURGERIES?

- [ ] Radical Prostatectomy
- [ ] Turp

CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD PREVIOUSLY OR CURRENTLY

- [ ] Thyroid disease
- [ ] Fibromyalgia/autoimmune disease
- [ ] Atherosclerosis
- [ ] Osteoporosis
- [ ] Low Sperm Count
- [ ] Cancer
- [ ] High Cholesterol
- [ ] Heart Disease
- [ ] High Blood Pressure
- [ ] Prostate Problems
- [ ] Sleep Apnea
- [ ] Other: _____

IS THERE A FAMILY HISTORY OF..?

- [ ] Thyroid disease
- [ ] Low Sperm Count
- [ ] High Blood Pressure
- [ ] Prostate Problems
- [ ] Atherosclerosis
- [ ] High Cholesterol

DO YOU USE TOBACCO PRODUCTS?

☐ Yes ☐ No

IF YES, IS YOUR DOCTOR AWARE?

☐ Yes ☐ No

IF YOU HAVE ANY QUESTIONS, PLEASE ASK THEM HERE

RATE THE FOLLOWING IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS RECENTLY

	0 None	1 Mild	3 Moderate	4 Severe
Sleep disruption/Insomnia	◯	◯	◯	◯
Decreased libido (sex drive)	◯	◯	◯	◯
Weakness	◯	◯	◯	◯
Depression	◯	◯	◯	◯
Fatigue	◯	◯	◯	◯
Erectile Dysfunction	◯	◯	◯	◯
Slow wound healing	◯	◯	◯	◯
Reduced muscle mass	◯	◯	◯	◯
Irritability	◯	◯	◯	◯
Nervousness/anxiety	◯	◯	◯	◯
Mood Swings	◯	◯	◯	◯
Weight Gain	◯	◯	◯	◯
Short term memory loss	◯	◯	◯	◯
Other: _____	◯	◯	◯	◯

HOW DID YOU HEAR ABOUT US?

☐ Radio ☐ TV Channel 9 ☐ Facebook ☐ Invitation in Mail ☐ YouTube

☐ TV Channel 41 ☐ Website ☐ Other