

### Male Hormone New Treatment Application

<b>Name</b>	<b>Date of Birth</b>	<b>Age</b>
<b>Street Address</b>	<b>City, State, Zip Code</b>	<b>Best Phone to Reach You</b>
<b>Cell Phone</b>	<b>Can We Leave A Message? Y N</b>	<b>Email</b>
<b>Employer</b>	<b>Occupation</b>	<b>Spouse / Partner</b>
<b>Emergency Contact/Phone</b>	<b>Primary Care Physician</b>	<b>Referred By</b>
<b>Height</b>	<b>Weight</b>	

<b>Medical History</b>	<b>Self</b>	<b>Fam</b>		<b>Self</b>	<b>Fam</b>		<b>Self</b>	<b>Fam</b>
Seizures			Asthma/COPD			Diarrhea		
Migraines or Headaches			Sleep Apnea			Liver Disease		
Dizziness			Pulmonary Hypertension			Gallbladder Disease/Stones		
Loss of Consciousness			Shortness of Breath			Ulcers		
Stroke			Irregular Heart Rhythm			Colitis		
Glaucoma			Heart Attack or Angina			Constipation		
Thyroid Disorder			Palpitations			Arthritis		
Obesity/Overweight			Heart Valve Disorder			Gout		
Diabetes Mellitus (DM)			Heart Failure			Osteopenia or Osteoporosis		
High Blood Sugar			High Blood Pressure			Kidney Disease or Stones		
Abnormal Cholesterol			Rheumatic Fever			Alcohol Abuse		
Insomnia			Tuberculosis			Drug Abuse		
Dementia			HIV			Eating Disorder		
Other:			Cancer Type:			Other Psychiatric Illness		

## Male Hormone New Treatment Application

### ALLERGIES

List all allergies to medications and reactions:

Medication	Reaction

Latex Allergy Yes \_\_\_\_\_ No \_\_\_\_\_

### CURRENT MEDICATIONS

Name of Medication	Dose Milligrams or Micrograms	# of Pills Daily	Date Started

### CURRENT SUPPLEMENTS (Vitamins, Minerals, Herbs, etc.)

Name of Supplement	Dose Milligrams or Micrograms	# of Pills Daily	Date Started

### PREVIOUS SURGERIES

Surgery / Procedure	Date

MEDICAL CARE	DATE	RESULTS OR FINDINGS
Physical Exam		
Rectal Exam		
PSA		

## Male Hormone New Treatment Application

Colonoscopy		
Cholesterol Check		
Cardiac Test (EKG, Echo, Stress, etc.)		

### DIET AND LIFESTYLE

List dietary restrictions or food allergies:

\_\_\_\_\_

Describe typical meals:

Breakfast	
Lunch	
Dinner	
Snacks	

HABITS	Yes	No	Amount / Type
Do you get regular exercise?			
Do you consume alcohol?			
Exercise regularly?			
Experience excessive stress?			

### REVIEW OF SYSTEMS

Please check YES to any symptom that you experience. For any YES answer please provide a brief description.

	Yes	If Yes, list physician you have seen and describe your condition and how long you have had it
Fever / Chills		
Excess Fatigue		
Weight Loss/Gain		
Frequent Bruising		
Blurry Vision		

## Male Hormone New Treatment Application

Frequent Bruising		
Enlarged Lymph Nodes		
Frequent Infections		
Cardiovascular		
Chest Pain at Rest or Exercise		
Cold Hands / Feet		
Swelling of Legs or Leg Cramps with Walking		
Heart Attack / Failure / Angina		
Mitral Valve / Murmur		
High Blood Pressure		
Gastrointestinal		
Constipation		
Diarrhea		
Bloating		
Excessive Belching		
Gas / Acidity		
Heartburn / Indigestion		
Ulcers		
Nausea / Vomiting		
Blood in Stool		
Thirst: Lack of / Too Much		
Genitourinary		
Pain on Urination		
Cloudy / Bloody Urination		
Urinating Too Often		
Difficulty Urinating		
Loss of Urine		

## Male Hormone New Treatment Application

Musculoskeletal		
Do you see a Chiropractor?		
Get regular body treatment / massage?		
Back or Neck Pain		
Joint Pain		
Weakness		
Prone to Falls		
Joint Deformity		
Ears, Nose, and Throat		
Ringing in Ears		
Hearing Difficulty / Loss		
Mouth Sores		
Nasal Stuffiness / Drainage		
Hoarseness		
Teeth or Gum Problems		
Snoring		
Sleep Apnea		
Pulmonary		
Shortness of Breath / Difficulty Breathing		
Persistent Cough		
Asthma / Wheezing		
Night Sweats		
Fever / Chills		
Skin		
Rashes		
Dry / Itchy Skin		

## Male Hormone New Treatment Application

Acne		
Moles / Lesion Changes		
Skin Color Changes		
Skin Growths / Cancer		
Hair / Nail Problems		
Neurologic		
Headaches / Migraines		
Dizziness / Nausea		
Fainting / Blackouts		
Numbness / Tingling		
Paralysis		
Coordination Problems		
Psychiatric		
Mental Illness		
Anxiety		
Depression		
Suicidal Thoughts		
Hallucinations		
Phobias		