

MALE PATIENT QUESTIONNAIRE

Name: _____ Today's Date: _____
(Last) (First) (Middle)

Date of Birth: _____ Age: _____ Occupation: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Email Address: _____

How did you hear about us? ☐ Patient (Name: _____) ☐ Event (_____)

☐ Practitioner (Name: _____) ☐ Pharmacy (Name: _____)

☐ Social Media (Type: _____) ☐ TV (Station: _____) ☐ Radio (Station: _____)

☐ Web (Keyword Searched: _____) ☐ Signage (_____) ☐ Print (Ad seen in: _____)

In Case of Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Pharmacy Name: _____ Phone: _____

Address: _____

Primary Care Physician's Name: _____ Phone: _____

Address: _____

May we share your clinical information with your PCP? ☐ Yes ☐ No

MEDICAL HISTORY

Weight: _____ Have you ever had any issues with anesthesia? () Yes () No

Any known drug allergies: () Yes () No If yes please explain: _____

Do you smoke? () Yes () No () Quit How much? _____ How often? _____ Age started? _____

Do you drink alcohol? () Yes () No () Quit How much? _____ How often? _____ Age started? _____

Current Medications and dosage: _____

Nutritional/Vitamin Supplements: _____

Current Hormone Replacement Therapy: _____ Past HRT: _____

Surgeries, list all and when: _____

Other Pertinent Information: _____

Do you have a family history of? () Heart Disease () Cancer () Diabetes () Other _____

Do you have a personal history of? Check all that apply.

() High blood pressure

() Hemochromatosis

() Trouble passing urine or take Flomax or Avodart

() High cholesterol

() Depression / anxiety

() Chronic liver disease (hepatitis, fatty liver, cirrhosis)

() Heart disease

() Psychiatric disorder

() Prostate enlargement

() Stroke

() Diabetes

() Elevated PSA

() Heart attack

() Thyroid disease

() Cancer:

() Blood clot or pulmonary emboli

() Arthritis

() Testicular or prostate Year: _____

() Other: _____ Year: _____

I understand that if I begin testosterone replacement with any testosterone treatment, including testosterone pellets, I will produce less testosterone from my testicles. And if I stop testosterone replacement I may experience a temporary decrease in my testosterone production. Testosterone pellets should be completely out of your system in 12 months.

PRINT NAME _____

SIGNATURE _____

DATE _____

AMS Checklist - BEFORE HRT

Place an "X" for EACH symptom you are currently experiencing. *Please mark only ONE box.*

☐ For symptoms that do not apply, please mark NONE.

	None	Mild	Moderate	Severe	Extremely Severe
1. Decline in your feeling of general well-being (general state of health, subjective feeling)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Joint pain and muscular ache (lower back pain, joint pain, pain in a limb, general back ache)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Excessive sweating (unexpected/sudden episodes of sweating, hot flushes independent of strain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Sleep problems (difficulty in falling asleep difficulty in sleeping through, waking up early and feeling tired, poor sleep, sleeplessness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Increased need for sleep, often feeling tired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Irritability (feeling aggressive, easily upset about little things, moody)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Nervousness (inner tension, restlessness, feeling fidgety)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Anxiety (feeling panicky)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Physical exhaustion / lacking vitality (general decrease in performance, reduced activity, lacking interest in leisure activities, feeling of getting less done, of achieving less, of having to force oneself to undertake activities)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Decrease in muscular strength (feeling of weakness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings, feeling nothing is of any use)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Feeling that you have passed your peak	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Feeling burnt out, having hit rock-bottom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Decrease in beard growth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Decrease in ability/frequency to perform sexually	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Decrease in the number of morning erections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Decrease in sexual desire/libido (lacking pleasure in sex, lacking desire for sexual intercourse)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please share any additional comments about your symptoms you would like to address. _____

Do you have cold hands and feet? ☐ Yes ☐ No

Do you have daily bowel movements? ☐ Yes ☐ No

Do you have gas, bloating or abdominal pain after eating? ☐ Yes ☐ No

Please select your WEEKLY Activity Level based on this criteria → *Physical activity that accelerates heart rate / Breathlessness*

☐ 0-1 day per week (Low) ☐ 2-3 days per week (Average) ☐ More than 3 days per week (High)

Please list any prior hormone therapy? _____

Recent PSA: _____ Recent Digital Rectal Exam (Date): _____ Normal / Abnormal

History of Prostate problems or Biopsy. If so, please provide details. _____

FOR OFFICE USE ONLY

CHART ID: _____ DOB: _____ APPT DATE: _____