Male Hormone Evaluation Intake Sheet

Name: _____ Date: _____

DOB: _____ Allergies: _____

Date of last prostate exam: _____ Where? _____

Symptoms	Yes	No		Yes	No
Erectile Dysfunction			Trouble sleeping/insomnia		
Decreased libido (sex drive)			Decreased self confidence		
Brain fog/Decreased mental clarity			Low motivation		
Loss of memory/trouble concentrating			Weight gain/increased body fat		
Fatigue/Decreased energy			Bone loss/decreased bone density		
Depression			Decreased muscle mass/strength		
Anxiety			Harder to build/maintain muscle		
Irritability			Decreased exercise tolerance/longer recovery time		

Are you currently on any testosterone replacement therapy (HRT) at this time? ☐Yes ☐No

If yes, name of HRT? _____

Have you been on any testosterone replacement in the past? ☐ Yes ☐ No

If yes, name of HRT? _____

Have you had a prostatectomy? ☐Yes ☐No

If yes, when and for what reason? _____

Do you have any history of cancer of any kind? ☐Yes ☐ No

Do you have any history of blood clots in your legs (DVT)or lungs (pulmonary embolism)? ☐Yes ☐No

Do you have any medical problems that require you to see your doctor regularly? ☐ Yes ☐ No

If yes, please list:_____

Have you been hospitalized for any reason in the last year? ☐Yes ☐ No

If yes, for what reason? _____

Do you have any history of joint replacement? ☐Yes ☐No

If yes, which joints? _____

Do you have a family history of breast, ovarian, colon or pancreatic cancer? ☐ Yes ☐ No

If yes, whom and at what age?

_____

_____

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