

Male Patient History & Questionnaire Bioidentical Hormone Replacement Therapy

First Name	Middle Initial	Last Name
Address		
City	State	Zip Code
DOB	Height	Weight
Email Address	Emergency Contact Name	Emergency Contact Phone Number
Home Phone	Work Phone	Cell Phone
Primary Care Provider	Phone Number	Date of last physical exam

What brings you in to see us today? _____

How did you hear about Rejuve? Web Search Facebook Friend/Family Instagram Other _____

May we send you a text message to remind you of your appointment? YES NO

May we contact you by email? YES NO

Medication History

List all Prescription Medications and dosages you are currently taking:	
1.	4.
2.	5.
3.	6.

List all Vitamins, Supplements, Over the Counter Medications and dosages you are currently taking:	
1.	5.
2.	6.
3.	7.

List all Past Hormone Medications with dosages & approximate start / stop dates:	
1.	5.
2.	6.
3.	7.

Report of Medical History

Do You Have Allergies to Medications? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, please list below:	
1.	4.
2.	5.
<input type="checkbox"/> YES <input type="checkbox"/> NO Do you Smoke?	If YES, how many cigarettes per day:
For how many years have you smoked?	
<input type="checkbox"/> YES <input type="checkbox"/> NO Do you drink alcohol?	If YES, how many drinks per week:
<input type="checkbox"/> YES <input type="checkbox"/> NO Do you wish to have children in the future?	
<input type="checkbox"/> YES <input type="checkbox"/> NO Have you had a physical exam?	If YES, date of last exam: ____ / ____ / ____
<input type="checkbox"/> YES <input type="checkbox"/> NO Have you had a prostate exam?	If YES, date of exam: ____ / ____ / ____
<input type="checkbox"/> YES <input type="checkbox"/> NO Abnormal prostate exam results?	If YES, provide date & details: ____ / ____ / ____

Medical History Continued:

Have you ever, or do you now have:

YES	NO	Don't Know	(PLEASE CHECK EACH)	YES	NO	Don't Know	(PLEASE CHECK EACH)	YES	NO	Don't Know	(PLEASE CHECK EACH)
			Scarlet fever, erysipelas				Leg cramps				STIs - chlamydia/HSV/etc
			Rheumatic fever				Frequent indigestion				HIV / AIDS
			Swollen or painful joints				Stomach / intestinal problems				Recent gain / loss of weight
			Frequent headaches				Gallbladder or gallstones				Arthritis / bursitis
			Dizziness or fainting				Jaundice or hepatitis				Recurrent back pain
			Ear, nose, throat trouble				Broken bones				Frequent trouble sleeping
			Wear glasses or contacts				Frequent or painful urination				Depression
			Chronic or frequent colds				Kidney stones				Loss of memory / amnesia
			Severe tooth/gum trouble				Sugar or albumin in urine				Nervousness / anxiety
			Sinusitis / Hay fever				Blood in urine				Loss of consciousness
			Head injury				Shortness of breath				Considering more children
			Thyroid Disorders				Chest pain or pressure				
			Asthma				Heart Palpitations				
			Chronic cough				Heart trouble				Allergy to grapeseed, sesame seed, cottonseed oil
			High/low blood pressure				Cancer				

Other medical conditions that you have been diagnosed with:

1.	
2.	
3.	
4.	

Surgical History:

1.		Date: ___ / ___ / ___
2.		Date: ___ / ___ / ___
3.		Date: ___ / ___ / ___

Family History

(Immediate family only, parents and siblings)

Do you have any family members with osteoporosis? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES , list each family member:
Do you have any family members that have had cancer? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES , list each family member with type and date:
Do you have any family members with diabetes? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES , list each:
Do you have any family members with cardiovascular disease? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES , list each:
Do you have any family members with blood clots? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES , list each:

Review of Hormone Symptoms

Rate the following symptoms: <ul style="list-style-type: none"> • Fill each field with a number between 0 and 10 • 0 = None 10 = Severe 		
Difficulty Falling Asleep	Water Retention	ED or loss of libido
Insomnia	Acne and/or oily Skin	Difficulty with urination
Irritability	Dry skin	Abnormal Hair Growth
Mood Swings	Dry hair or hair loss	Constipation
Difficulty Concentrating	Headaches	Cold Hands or Feet
Weight Gain		

Other Symptoms:

Please answer the following questions so that your Provider is better able to understand your symptoms: 1 = I feel terrible 10 = I feel awesome

Energy 30 min after you wake up

1 2 3 4 5 6 7 8 9 10

Energy in the afternoon

1 2 3 4 5 6 7 8 9 10

Libido

1 2 3 4 5 6 7 8 9 10

Stress level (1 = Low, 10 = High)

1 2 3 4 5 6 7 8 9 10

Anxiety (1 = Low, 10 = High)

1 2 3 4 5 6 7 8 9 10

Memory (1 = Low, 10 = High)

1 2 3 4 5 6 7 8 9 10

Pain (1 = Low, 10 = High)

1 2 3 4 5 6 7 8 9 10

Any acid reflux / bloating symptoms? YES NO

Weight – happy / not happy? YES NO (If NO, how much would you like to lose?)

Loss of Strength / Muscle Mass - despite regular exercise? YES NO

Erectile Dysfunction? YES NO

Number of bowel movements a day? _____

Hours of uninterrupted sleep nightly? _____

Patient Signature: _____ **Date:** _____