PHYSICIAN'S weight control & wellness

Bio-Identical Hormone Replacement Questionnaire for Men

Name:_____ Today's Date:_____
Address:_____ City:_____ State:_____ Zip:_____
Home or Cell Phone:_____ Work Phone:_____ Email:_____
Date of Birth:_____ Age:_____ Spouse's Name:_____
Occupation:_____ Employer:_____
Work activity level: ☐ sedentary ☐ mildly active ☐ very active physically demanding
What are the ages of your children: _____ How did you hear about us: _____

Briefly Describe Your Present Symptoms: _____
_____
What do you feel is the most important factor to your present symptoms? _____
_____

Medical History – List all medical problems or illnesses you have or have had; include hospitalizations for illnesses or accidents.

Date	Describe the Medical Diagnosis – was this an Illness or an Accident

Surgical History

Date	Surgery

Medications – List ALL prescription medications and ALL over the counter medications including vitamins

Name of Medication	Dosage	Schedule

Allergies to Medications – List ALL MEDICATIOINS (prescriptions or over the counter) you are allergic to

Medication	What happens when you take it

Family History – List ALL illnesses (heart disease, stroke, diabetes, hypertension, cancer of any type), etc.

Relationship	Age when occurred	Medical Problem (If Death occurred list Problem and age at time of Death)
Mother		
Father		
Brothers		
Sisters		
Children		
Spouse		

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Social History – This information is strictly confidential and will be used only to address symptoms and/or complaints

Do you smoke cigarettes now or have you in the past? Yes____ No____ If yes, how many packs per day? _____ How many years have you, or did you smoke? _____
Do you drink alcohol? Yes____ No____ If yes, how many drinks do you usually have in a week? _____ What do you usually drink (beer, wine, bourbon, etc.)? _____
Do you now, or have you ever used illicit drugs (marijuana, amphetamines, narcotics, psychedelics, cocaine, etc.)? Yes___ No___ If yes, what substance and how often? _____

Check-up History

Date of last PSA: _____ Date of last complete check-up? _____
Physician:_____ Facility?_____
Physician's Phone #_____ Facility's Phone #_____
Primary Care Physician _____

Have you ever had an abnormal PSA? If yes, what was the abnormality and follow up you had? _____	Yes____	No____
Have you ever had an abnormal test If yes, what was the abnormality and follow up you had? _____	Yes____	No____
Have you ever had any kind of prostate problems? _____	Yes____	No____

Do you have a history of any type of **cancers**:
Date: _____ Type:_____
Date:_____ Type:_____
Do you exercise regularly? Yes____ No____ If yes, what type of exercise do you do?_____

How would you rate the current level of stress in your life at this time?
(Please circle) No Stress—1—2—3—4—5—6—7—8—9- Very Stressed

Do you sleep well? Yes_____ No_____ Describe your typical sleep pattern _____
_____
Do you currently have major life stressors? ____marriage ____children ____finances ____job
Other _____
Do you eat a healthy diet? Yes____ No____ Explain if no_____

Hormone Therapy History: If you have ever been treated with hormone replacement, either prescription or over the counter, please list and give the reason for treatment.

Hormone	Dose	Reason	Start Date	Stop Date

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Androgens: (check if troublesome and/or persistent)

Androgen Excess Androgen Deficiency

Increased Body Hair	
Acne	
Oily Skin	
Nervous	
Irritable/Irritable	
Anxious	
Depressed	
Sleep Disturbances	

Androgen Deficiency

Low Libido	
Fatigue	
Aches/Pains	
Memory Lapses	
Foggy Thinking	
Depressed	
Anxious/Irritable	
Sleep Disturbances	
Thinning Skin	
Decreased Muscle Mass	
Headaches	

Adrenals: (check if troublesome and/or persistent)

Cortisol Excess

Sleep Disturbances		Acne	
Sugar Cravings		Memory Loss	
Fatigue		Increased Body Hair	
Weight Gain – mid section		Headaches	
Loss of Muscle Mass		Stress	
Thinning Skin		Cold Body Temperature	
Elevated Triglycerides		Hair Loss	
Low Libido			
Irritable/Anxious/Nervous			

Cortisol Deficiency

Fatigue	
Sugar Craving	
Allergies	
Chemical Sensitivity	
Stress	
Cold Body Temperature	
Irritable	
Arthritis	
Aches/Pains	

Thyroid: (check if troublesome and/or persistent)

Thyroid Excess

Heat Intolerance	
Insomnia	
Palpitations	
Weight Loss	
Tremors/Shakiness	
Diarrhea	
Nervousness/Anxious/Panic Attacks	
Muscle Weakness	
Coarse Dry Skin	

Thyroid Deficiency

Cold Intolerance	
Constipation	
Fatigue/Weakness	
Unexplained Weight Gain	
Inability to Lose Weight	
Lack of Motivation	

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System Review – Check the appropriate box for each question.

Constitutional / ID / Oncology	Yes	No
Have you had unexplained weight loss?		
Do you have fever of chills?		
Do have night sweats?		
Do you notice swollen lymph nodes?		
Have you ever been diagnosed with cancer?		
Have you ever tested positive of HIV?		
Have you ever had a sexually transmitted disease?		
Respiratory	Yes	No
Do you have a cough?		
Do you frequently sneeze?		
Do you have excessive daytime sleepiness?		
Do you snore?		
Have you ever been diagnosed with asthma or emphysema		
Cardiovascular	Yes	No
Do you have chest pain?		
Do you have palpitations?		
Do you have shortness of breath?		
Do you have swelling in your legs?		
Do you have leg pain while walking?		
Have you been diagnosed with any heart condition?		
Have you ever been diagnosed with a blood clot?		
Gastrointestinal	Yes	No
Do you have trouble swallowing food? (reflux)		
Do you have nausea or vomiting?		
Do you have diarrhea?		
Do you have blood in your stool?		
Do you have abdominal pain or swelling?		
Have you ever been diagnosed with hepatitis or liver disease?		
Endocrine	Yes	No
Do you urinate frequently or in larger amounts than usual?		
Do you have a greater than normal urge to eat?		
Are you excessively thirsty?		
Do you have acne?		
Have you ever been diagnosed with a thyroid problem?		
Neurological	Yes	No
Do you have muscle weakness?		
Have you ever had a seizure?		
Have you experience double vision or blind spots?		
Have you ever been diagnosed with a stroke?		
Do you have burning when you urinate?		
Do you have urgency when you urinate?		
Do you urinate more frequently than others?		
Do you leak urine when laughing or coughing?		
Have you ever had any kidney problems?		

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MEDICAL HISTORY QUESTIONNAIRE: Patient will submit a truthful, accurate, and complete Medical History Questionnaire. Patient also acknowledges that failure to provide accurate, truthful, and complete information on this Questionnaire to the Physician(s) of Physician's Weight Control and Wellness Centers could result in inappropriate treatment. _____
Initial

(All information contained in this questionnaire is strictly confidential, will be protected to the highest of HIPAA standards, and will become part of your PWCWC medical record.)

Patient's Signature_____ Date_____

Physician's Signature_____ Date_____

Doctor's Notes:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____