

Seasons Healthcare

Hormone Evaluation / Medical History

Today's Date: _____

Name: _____ SS #: _____ Birth date: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ (Home) _____ (Work) _____ (Cell)

Gender: ___ Male ___ Female E-Mail Address: _____

Occupation: _____ Employer: _____

Marital Status: _____ Name of Spouse/Partner: _____

Referred by: _____

Emergency Contact: _____ Relationship: _____

Home Telephone: _____ Work Telephone: _____

Why have you come to the office today? _____

Please describe your problem, including where it is, how severe it is, and how long it's lasted: _____

Current Doctor's Name: Address: Phone: Specialty:

Allergies: Please check all that apply.

___ Penicillin ___ Morphine ___ Dye Allergies ___ Pet Allergies

___ Codeine ___ Aspirin ___ Nitrate Allergy ___ Seasonal Allergy

___ Sulfa Drug ___ Food Allergies ___ No Known Drug Allergies

Other: _____

Please describe the allergic reaction you experienced and when it occurred?

Current Prescription Medications: _____ currently **not** taking any medication

Medication Name Strength How often per day? Date Started

Over-the-counter (OTC) issues:

Please check all products that you use occasionally or regularly. Check all that apply.

- Pain Reliever
- Aspirin
- Acetaminophen (Ex: Tylenol)
- Ibuprofen (Ex: Motrin)
- Naproxen (Ex: Aleve)
- Ketoprofen (Ex: Orudis KT)
- Cough Suppressant (Ex: Robitussin DM)
- Antihistamine Product (Ex: Chlor-Trimeton)
- Decongestant Product (Ex: Sudafed)
- Combination Product (Cough+Cold Reliever) (Ex: Triaminic DM.)
- Sleep Aids (Ex: Excedrin PC, Unisom, Sominex, Nytol)
- Antidiarrheals (Ex: Imodium, Pepto Bismol, Kaopectate)
- Laxatives/Stool Softeners (Ex: Doxidan, Correctol, etc.)
- Diet Aids/Weight Loss Products (Ex: Dexatril)
- Antacids (Ex: Maalox, Mylanta)
- Acid Blockers (Ex: Tagamet HB, Pepcid C, Zantac 75)
- Other (Please list) _____

Nutritional/Natural Supplements: Please identify and list the products you are using.

- Vitamins (Ex: Multiple or simple vitamins such as B complex, E, C, Beta Carotene)
- Minerals (Ex: Calcium, Magnesium, Chromium, Colloidal Minerals, Various Single Minerals.)
- Herbs (Ex: Ginseng, Ginkgo Biloba, Echinacea, Other Herbal Medicinal Teas, Tinctures, etc.)
- Enzymes (Ex: Digestive formulas, Papaya, Bromelain, CoEnzyme Q10, etc.)
- Nutrition/Protein Supplements (Ex: Shark Cartilage, Protein Powers, Amino Acids, Fish Oils)
- Others (Ex: Glucosamine, etc.)

Medical Conditions/Diseases: Please check all that apply to you.

- Heart Disease (Ex. Congestive Heart Failure)
- High Cholesterol or Lipids (Ex: Hyperlipidemia)
- High Blood Pressure (Ex: Hypertension)
- Cancer *Type:* _____
- Ulcers (Stomach, Esophagus)
- Thyroid Disease
- Hormonal Related Issues
- Lung Condition (Ex: Asthma, Emphysema, COPD)
- Blood Clotting Problems
- Diabetes
- Arthritis or Joint Problems
- Depression
- Epilepsy
- Headaches/Migraines
- Eye Disease (Glaucoma, etc)
- Other :(Please list) _____

Family History: Please check all that apply & list which relative(s):

- Heart Disease (Ex. Congestive Heart Failure) _____
- High Blood Pressure (Ex: Hypertension) _____
- High Cholesterol or Lipids (Ex: Hyperlipidemia) _____
- Diabetes _____
- Lung Condition (Ex: Asthma, Emphysema, COPD) _____
- Blood Clotting Problems _____
- Ulcers (Stomach, Esophagus) _____
- Cancer _____
- Depression _____
- Thyroid Disease _____
- Headaches/Migraines _____
- Other: _____

Social History:

- Do you use tobacco? Yes No
- Do you use alcohol? Yes No
- Do you use caffeine? Yes No
- Do you use a seat belt? Yes No
- Do you exercise regularly? Yes No

How often and how much?

- _____
- _____
- _____
- _____

Surgical History/Hospitalization:

Date

Patient Name: _____

List Hormones previously taken.	Date Started	Date Stopped	Reason
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How did you arrive at the decision to consider Bio-identical Hormone Replacement Therapy?

___ Doctor ___ Self ___ Friend/Family Member ___ Other

What are your goals with taking BHRT?

Please write down any questions you have about BHRT.

Patient Name: _____

Men's Health Profile/Questionnaire

Circle **Yes** or **No** to the following questions. If yes, indicate if **Mild**, **Moderate**, or **Severe**.

1. Do you feel more fatigued and/or tired than usual? **Yes** **No**
If yes, Circle **Mild** **Moderate** **Severe**
2. Have you noticed a decrease in your muscle mass? **Yes** **No**
If yes, Circle **Mild** **Moderate** **Severe**
3. Have you experienced a loss in muscle strength? **Yes** **No**
If yes, Circle **Mild** **Moderate** **Severe**
4. Have you experienced an increase in joint and/or muscle pains? **Yes** **No**
If yes, Circle **Mild** **Moderate** **Severe**
5. Have you noticed an increase in your waist size? **Yes** **No**
If yes, Circle **Mild** **Moderate** **Severe**
6. Do you have trouble losing weight? **Yes** **No**
If yes, Circle **Mild** **Moderate** **Severe**
7. Have you experienced a loss in height? **Yes** **No**
If yes, Circle **Mild** **Moderate** **Severe**
8. Do you have a decrease in your sex drive? **Yes** **No**
If yes, Circle **Mild** **Moderate** **Severe**
9. Have you experienced difficulty in establishing and/or maintaining full erections? **Yes** **No**
If yes, Circle **Mild** **Moderate** **Severe**
10. Do you have a decrease in spontaneous early morning erections? **Yes** **No**
If yes, Circle **Mild** **Moderate** **Severe**
11. Do you have a history of Erectile Dysfunction? **Yes** **No**
If yes, Circle **Mild** **Moderate** **Severe**
12. Have you experienced changes in your usual sleep pattern? **Yes** **No**
If yes, Circle **Mild** **Moderate** **Severe**
13. Do you feel a decrease in your mental sharpness? **Yes** **No**
If yes, Circle **Mild** **Moderate** **Severe**
14. Have you had trouble concentrating? **Yes** **No**
If yes, Circle **Mild** **Moderate** **Severe**

15. Do you experience less enjoyment in personal interests and hobbies? **Yes** **No**
 If yes, Circle **Mild Moderate Severe**

16. Do you have a history of Benign Prostatic Hyperplasia? **Yes** **No**
 If yes, Circle **Mild Moderate Severe**

17. I am _____ years old. I feel _____ years old.

Patient Name: _____

Review of Systems

Physician's Notes

Constitutional

Weight Loss	___ Now	___ Past	___ Not Sure	_____
Weight Gain	___ Now	___ Past	___ Not Sure	_____
Fever	___ Now	___ Past	___ Not Sure	_____
Fatigue	___ Now	___ Past	___ Not Sure	_____
Change in Height	___ Now	___ Past	___ Not Sure	_____

Eyes

Double Vision	___ Now	___ Past	___ Not Sure	_____
Spots Before Eyes	___ Now	___ Past	___ Not Sure	_____
Vision Changes	___ Now	___ Past	___ Not Sure	_____
Glasses/Contacts	___ Now	___ Past	___ Not Sure	_____

Ear, Nose, and Throat

Earaches	___ Now	___ Past	___ Not Sure	_____
Ringing in Ears	___ Now	___ Past	___ Not Sure	_____
Sinus Problems	___ Now	___ Past	___ Not Sure	_____
Sore Throat	___ Now	___ Past	___ Not Sure	_____
Mouth Sores	___ Now	___ Past	___ Not Sure	_____
Dental Problems	___ Now	___ Past	___ Not Sure	_____

Cardiovascular

Painful Breathing	___ Now	___ Past	___ Not Sure	_____
Chest Pain/Pressure	___ Now	___ Past	___ Not Sure	_____
Difficulty Breathing on Exertion	___ Now	___ Past	___ Not Sure	_____
Swelling of Legs	___ Now	___ Past	___ Not Sure	_____
Rapid or Irregular Heartbeat	___ Now	___ Past	___ Not Sure	_____

Respiratory

Wheezing	___ Now	___ Past	___ Not Sure	_____
Spitting up Blood	___ Now	___ Past	___ Not Sure	_____
Shortness of Breath	___ Now	___ Past	___ Not Sure	_____
Chronic Cough	___ Now	___ Past	___ Not Sure	_____

Gastrointestinal

Frequent Diarrhea	___ Now	___ Past	___ Not Sure	_____
Bloody Stool	___ Now	___ Past	___ Not Sure	_____
Nausea/Vomiting/Indigestion	___ Now	___ Past	___ Not Sure	_____
Constipation	___ Now	___ Past	___ Not Sure	_____
Involuntary Loss of Gas or Stool	___ Now	___ Past	___ Not Sure	_____

Neurologic

Dizziness	___ Now	___ Past	___ Not Sure	_____
Seizures	___ Now	___ Past	___ Not Sure	_____
Numbness	___ Now	___ Past	___ Not Sure	_____
Trouble Walking	___ Now	___ Past	___ Not Sure	_____
Severe Memory Problems	___ Now	___ Past	___ Not Sure	_____
Frequent/ Severe Headaches	___ Now	___ Past	___ Not Sure	_____

Patient Name: _____

Genitourinary

Blood in Urine	___ Now	___ Past	___ Not Sure	_____
Pain with Urination	___ Now	___ Past	___ Not Sure	_____
Strong Urgency to Urinate	___ Now	___ Past	___ Not Sure	_____
Frequent Urination	___ Now	___ Past	___ Not Sure	_____
Incomplete Emptying	___ Now	___ Past	___ Not Sure	_____
Involuntary Urine Loss	___ Now	___ Past	___ Not Sure	_____
Urine loss when Coughing/Lifting	___ Now	___ Past	___ Not Sure	_____
Abnormal Bleeding	___ Now	___ Past	___ Not Sure	_____
Painful Periods	___ Now	___ Past	___ Not Sure	_____
Premenstrual Syndrome (PMS)	___ Now	___ Past	___ Not Sure	_____
Painful Intercourse	___ Now	___ Past	___ Not Sure	_____
Fibroids	___ Now	___ Past	___ Not Sure	_____
Infertility	___ Now	___ Past	___ Not Sure	_____
Des Exposure	___ Now	___ Past	___ Not Sure	_____
Abnormal Vaginal Discharge	___ Now	___ Past	___ Not Sure	_____

Skin

Rash	___ Now	___ Past	___ Not Sure	_____
Sores	___ Now	___ Past	___ Not Sure	_____
Dry Skin	___ Now	___ Past	___ Not Sure	_____
Moles	___ Now	___ Past	___ Not Sure	_____

Breast

Pain in Breast	___ Now	___ Past	___ Not Sure	_____
Nipple Discharge	___ Now	___ Past	___ Not Sure	_____
Lumps	___ Now	___ Past	___ Not Sure	_____

Musculoskeletal

Muscle Weakness	___ Now	___ Past	___ Not Sure	_____
Muscle or Joint Pain	___ Now	___ Past	___ Not Sure	_____

Psychiatric

Depression/Frequent Crying	___ Now	___ Past	___ Not Sure	_____
Severe Anxiety	___ Now	___ Past	___ Not Sure	_____

Endocrine

Hair Loss	___ Now	___ Past	___ Not Sure	_____
Heat/Cold Intolerance	___ Now	___ Past	___ Not Sure	_____
Abnormal Thirst	___ Now	___ Past	___ Not Sure	_____

Hot Flashes ___ Now ___ Past ___ Not Sure _____

Hematologic/Lymphatic

Frequent Bruises ___ Now ___ Past ___ Not Sure _____

Cuts Do Not Stop Bleeding ___ Now ___ Past ___ Not Sure _____

Enlarged Lymph Nodes ___ Now ___ Past ___ Not Sure _____

Form Completed by: ___ Patient ___ Nurse ___ Physician ___ Other

Print Name: _____

Signature of Patient: _____