HORMONE BALANCE QUESTIONNAIRE FOR MEN

Name:				Date:
Address:		City:	State:	Zip:
Home Phone:	Cell Phone:		Work Phone:	
Date of Birth:	Age:	Height:	Weight:	
Primary Care Doctor:				

HEALTH HISTORY

Do you have a personal or family history of any of the following?

Prostate Cancer ☐ No ☐ Yes (*who?)*____________________________

Breast Cancer ☐ No ☐ Yes (*who?)*____________________________

Osteoporosis ☐ No ☐ Yes (*who?)*____________________________

Have you had any of the following tests?

PSA ☐ No ☐ Yes (*Date)*____________ Abnormal? ☐ No ☐ Yes

MEDICAL CONDITIONS / DISEASES *(please check all that apply)*

☐ Heart Disease (heart attack, CHF, etc.)	☐ Blood Clotting Problems
☐ High Cholesterol	☐ Diabetes
☐ High Blood Pressure	☐ Arthritis or Joint Problems
☐ Cancer (type ________)	☐ Depression
☐ Ulcers (stomach, esophagus)	☐ Epilepsy or Seizure Disorder
☐ Thyroid Problems	☐ Headaches / Migraines
☐ Hormone Related Issues	☐ Eye Disease (glaucoma, etc.)
☐ Lung Problems (asthma, COPD, etc.)	☐ Liver or Gastrointestinal Disorder
Other *(please explain)*	

Have you had prostate surgery? ☐ No ☐ Yes (*date of surgery)*________________________

PREVIOUS SURGERIES / HOSPITALIZATIONS *(please list)*

Please list any other surgeries you have had:

_______________________________ _______________________________

_______________________________ _______________________________

_______________________________ _______________________________

_______________________________ _______________________________

Do you smoke? ☐ Yes ☐ No (*details)* ____

Do you drink alcohol ☐ Yes ☐ No (*details)* ____

Do you use recreational drugs? ☐ Yes ☐ No (*details)* ____

Do you exercise? ☐ Yes ☐ No (*details)* ____

LIFESTYLE

☐ I have no allergies or medication intolerances that I know of

ALLERGIES / MEDICATION INTOLERANCES *(please list)*

MEDICATIONS

Current Prescription and Over-the-Counter Medications

_______________________________ _______________________________

_______________________________ _______________________________

_______________________________ _______________________________

List Hormones Currently or Previously Taken

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

NUTRITIONAL SUPPLEMENTS

Please circle the product you are using:

- ☐ Vitamins (multiple or single vitamins such as B complex, E, C, D, beta carotene, other)
- ☐ Minerals (calcium, magnesium, chromium, iron, zinc, coper, other)
- ☐ Herbs (ginseng, gingko biloba, echinacea, medicinal teas, other)
- ☐ Enzymes (Digestive, papaya, bromelain, CoQ10, other)

Other *(please specify):*

- ☐ Nutritional/Protein Supplements (shark cartilage, protein powders, amino acids, fish/flaxseed oil, other)
- ☐ I do not currently take any nutritional supplements

CURRENT SYMPTOMS

For each item identified below, circle the number that best fits the symptoms you are experiencing

0 = none ▪ 1 = mild ▪ 2 = moderate ▪ 3 = severe

Item					Item				
Decreased Muscle Mass	0	1	2	3	Reduced Energy	0	1	2	3
Weight Gain	0	1	2	3	Loss of Sex Drive	0	1	2	3
Difficulty Falling Asleep	0	1	2	3	Erectile Dysfunction	0	1	2	3
Difficulty Staying Asleep	0	1	2	3	Urinary Problems	0	1	2	3
Morning Fatigue	0	1	2	3	Urinary Tract Infections	0	1	2	3
Evening Fatigue	0	1	2	3	Urinary Incontinence	0	1	2	3

Item					Item				
Depression	0	1	2	3	Dry / Brittle Nails	0	1	2	3
Anxiety	0	1	2	3	Dry / Brittle Hair	0	1	2	3
Irritable	0	1	2	3	Sugar / Carb Cravings	0	1	2	3
Memory Lapses	0	1	2	3	Unusual Sweating	0	1	2	3
Foggy Thinking	0	1	2	3	Hoarseness	0	1	2	3
Stress	0	1	2	3	Slowed Reflexes	0	1	2	3
Thinning Skin	0	1	2	3	Cold Body Temperature	0	1	2	3
Oily Skin	0	1	2	3	Blood Pressure Problems	0	1	2	3

What are your goals with Bioidentical Hormone Replacement Therapy (BHRT)?

Please write down any questions you have about BHRT:

_______________________________ _______________________

Patient Signature **Date**