MEN'S HEALTH QUESTIONNAIRE

General Information

Name_____ Date_____

Date of Birth_____ Age_____ Height _____ Weight_____

Primary Phone_____ Email _____

Address_____ Apt/Ste_____

City_____ State_____ Zip_____

Occupation _____ ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Other

Living Situation ☐ Spouse ☐ Alone ☐ Partner ☐ Parents ☐ Children ☐ Other _____

Pets? _____

How did you hear about Bio-Identical Hormone Replacement Therapy?

☐ Another Patient ☐ Books/Articles ☐ Course/Seminar ☐ Ads

☐ Physician/Healthcare ☐ Pharmacy Solutions ☐ Other

Please describe your current level of understanding of Bio-Identical Hormone Replacement Therapy.

_____

_____

Please list some health goals you have with the help of Bio-Identical Hormone Replacement Therapy.

_____

_____

_____

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General Health Information

How would you rate your current general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Current diagnosis and medical conditions _____

Drug allergies _____

Allergies to food, pollens, etc. _____

Current medications _____

Current vitamins/OTC products _____

Current herbs, etc. _____

Have you ever had your cholesterol level checked? ☐ No ☐ Yes, Date _____ Results _____

Current/Recent Health Care Provider(s)_____

Medical History Information

Please check any past or current medical conditions that that apply to you.

☐ Childhood Disease _____
☐ Cardiovascular Disease _____
☐ Cancer _____
☐ Other _____

☐ Arthritis	☐ Diabetes	☐ High Cholesterol
☐ Asthma / COPD	☐ Epilepsy	☐ Insomnia
☐ BPH (Benign Prostatic Hyperplasia)	☐ Erectile Dysfunction	☐ Kidney Trouble
☐ Chronic Fatigue	☐ Fractures	☐ Malnutrition
☐ Cron's/Colitis	☐ Gallbladder Trouble	☐ Osteoporosis
☐ Depression	☐ High Blood Pressure	☐ Stroke

MEN'S HEALTH QUESTIONNAIRE

Family Medical History

Please list family members and their age who are *still living* that have health conditions such as:
High Blood Pressure, Heart Disease, Cancer, Diabetes, Osteoporosis, Etc.

_____

_____

_____

Please list family members who died and their *age at death* of health conditions such as:
High Blood Pressure, Heart Disease, Cancer, Diabetes, Osteoporosis, Etc.

_____

_____

_____

Current Lifestyle & Habits

Please describe any dietary restrictions _____
Common Meal Choices:
Breakfast _____

Lunch _____

Dinner_____

Do you get routine physical exercise? ☐ No ☐ Yes, what type _____

Do you use tobacco products? ☐ No ☐ Yes, how much? _____ ☐ Previously, how long?_____

Do you use alcohol products? ☐ No ☐ Yes, how much? _____ ☐ Previously, how long?_____

Do you use caffeine products? ☐ No ☐ Yes, how much? _____ ☐ Previously, how long?_____

MEN'S HEALTH QUESTIONNAIRE

General Health Evaluation

Please select the best answer for the following.

I am ____ years old. I feel like I am ____ years old.

Do you feel more fatigued and/or tired than usual?
☐ None ☐ Mild ☐ Moderately ☐ Severely

Have you noticed a decrease in your muscle mass?
☐ None ☐ Mild ☐ Moderately ☐ Severely

Have you experienced a loss in muscle strength?
☐ None ☐ Mild ☐ Moderately ☐ Severely

Have you experienced an increase in joint and/or muscle pains?
☐ None ☐ Mild ☐ Moderately ☐ Severely

Have you noticed an increase in your waist size?
☐ None ☐ Mild ☐ Moderately ☐ Severely

Do you have trouble losing weight?
☐ None ☐ Mild ☐ Moderately ☐ Severely

Have you experienced a loss in height?
☐ None ☐ Mild ☐ Moderately ☐ Severely

Have you noticed a decrease in your sex drive?
☐ None ☐ Mild ☐ Moderately ☐ Severely

Have you experienced difficulty in establishng and/or maintaining full erections?
☐ None ☐ Mild ☐ Moderately ☐ Severely

Do you have a decrease in spontaneous early morning erections?
☐ None ☐ Mild ☐ Moderately ☐ Severely

Have you experienced changes in your sleep pattern?
☐ None ☐ Mild ☐ Moderately ☐ Severely

Do you feel a decrease in your mental sharpness?
☐ None ☐ Mild ☐ Moderately ☐ Severely

Have you had trouble concentrating?
☐ None ☐ Mild ☐ Moderately ☐ Severely

Do you experience less enjoyment in personal interest and hobbies?
☐ None ☐ Mild ☐ Moderately ☐ Severely

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Select the following symptoms as they apply to you over the last **30 day period**.

Fatigue, tiredness, especially in late afternoon/early evening
☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

Depression, negative mood
☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

Irritability, anger, bad temper
☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

Anxiety or nervousness
☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

Loss of memory, concentration
☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

Relationship problem with your partner
☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

Loss of sex drive
☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

Problem with obtaining an erection
☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

Problem with maintaining an erection
☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

Loss of early morning erections
☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

Dry skin on face or hands
☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

Excessive sweating — day or night
☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

Backache, joint pains, stiffness
☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

Heavy drinking — past or present
☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

Loss of fitness, muscle strength
☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

Unexplained weight gain, mainly in the midsection
☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

Decrease in initiative, drive
☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

Falling asleep much earlier than in the past
☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

Decrease in competitiveness
☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

Increase in frequency of urination
☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe