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# Male Hormone Patient Profile

Name: _____ Date: _____

Address:_____

Cell Phone: _____ Home phone: _____ Work Phone: _____

Email: _____

**Drug Allergies:**_____

Date of Birth: _____ Height: _____ Weight: _____

Name of Physician: _____ Phone #:_____

May we leave you a voice message? _____ Home _____ Cell

May we text message you when your medications are ready? ____Yes ____No
If yes, which company services your cell phone? (ex. Verizon, AT&T, etc.): _____

Which method of communication do you prefer? ____ Text Message ___ Email ____Voicemail

Do you have prescription insurance? ____Yes ____No
If yes, please provide a copy of the insurance card or bring it to the appointment.

Who referred you to us?_____

List of Current Medications (Include Supplements, OTC, and prescriptions):

_____
_____
_____
_____

Marital Status: ____Single ____ Married ____ Divorced ____ Widowed

Number of Children: _____ Are you planning on having any more children? ____Yes ____No

Do you take Calcium daily? ___Yes ___ No
If yes, how much? _____

Do you take Vitamin D daily? ___ Yes ___ No
If yes, how much? _____

Do you take Omega III (Fish Oil) daily? ___ Yes ___ No

Name:_____

If yes,

**Lifestyle**

Do you smoke? ___Yes ___No
If yes, how many per day? _____

Do you consume alcohol? ___ Yes ___No
If yes, how much? ____ Little ____ Moderate ____Excessive
If yes, what kind of alcohol? _____

How much caffeine do you consume per day? _____

Are you sexually active? ____ Yes ____ No
If yes, how often? _____ Sexual Orientation: _____

Do you exercise? ____ Yes ____ No
If yes, how many times per week do you exercise? _____
If yes, what kind of exercise? _____
If yes, do you do any upper body exercise? _____

What is your stress level? _____ Mild _____ Moderate _____ Severe

Do you use any recreational drugs? ____ Yes ____ No
If yes, please name: _____

**Medical History**

Do you have any family history of cancer? ___Yes ___ No
If yes, what type of cancer and how they are related:

_____
_____

Is your mother deceased? _____ If yes, cause of death:_____

Is your father deceased? _____ If yes, cause of death:_____

Medical Conditions:

_____
_____
_____

Have you taken any hormones in the past? ___ Yes ___ No

Name:_____

If yes, please explain:

_____
_____

Please list any other past surgeries:

_____
_____
_____

Date of your last bone density test: _____ Normal results? ___ Yes ___ No

Have you had a vasectomy? ___ Yes ___ No
If yes, when?_____

Please list your chief complaints:

_____
_____
_____
_____

**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**

Name:_____

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 **Yes No**
full erections?
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. Have you experienced changes in your usual sleep pattern? **Yes No**
If yes, circle: **Mild Moderate Severe**

12. Do you feel a decrease in your mental sharpness? **Yes No**
If yes, circle: **Mild Moderate Severe**

13. Have you had trouble concentrating? **Yes No**
If yes, circle: **Mild Moderate Severe**

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

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**Pharmacists may not prescribe medications. Recommendations made by our pharmacists must be approved by the patient's prescriber. By signing below, I hereby acknowledge that the risks and benefits of hormone therapy have been explained to me and my questions have been answered.**

**Patient Signature: _____ Date:_____**