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Confidential Male Medical History Form

Today's Date: _______________

Date of Consult: _______________

Name: ____ Date of Birth: _________________ Age: ____________

Address: ____

City: _______________________________ State: _________ Zip: ________________

Phone (Home): _____________________ Work: ____________________ Email: ________________________________

Best Time to Call: ____

Occupation: ________________________ Full Time: ___ Part Time: ___ Retired: ___ Unemployed: ___ Other: ___

Living Situation: Spouse: ___ Alone: ___ Partner: ___ Friend(s): ___ Parents: ___ Children: ___ Other: ___

Marriage Status: Married: ___ Single: ___ Divorced: ___ Widowed: ___

Height: __________ Weight: __________ BMI: _________

Pets: ____

How did you arrive at the decision to consider Bioidentical Hormone Replacement Therapy?

Doctor: __________ Self: __________ Family Member/ Friend: __________ Other: __________

What are your goals for taking BHRT?

____

____

Doctor's Name: Address: Phone:

____

____

____

Last Name: ______________

____

____

____

Allergies: Please check all that apply:

_____ Penicillin _____ Morphine _____ Dye Allergies

_____ Codeine _____ Aspirin _____ Nitrate Allergies

_____ Sulfa Drug _____ Food Allergies _____ No Known Allergies

_____ Pet Allergies _____ Seasonal (Pollen) _____ Other

Please describe the allergic reaction you experienced when it occurred:

____

____

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

_____ Heart Disease (ex. Congestive Heart Failure)

_____ High Blood Pressure (ex. Hypertension)

_____ Lung Condition (ex. Asthma, Emphysema, COPD)

_____ High Cholesterol or Lipids (ex. Hyperlipidemia)

_____ Diabetes

_____ Arthritis or Joint Problems

_____ Cancer

_____ Depression

_____ Ulcers (stomach, esophagus)

_____ Epilepsy

_____ Thyroid Disease

_____ Headaches/ Migraines

_____ Hormonal Related Issues

_____ Eye Disease (Glaucoma, etc.)

_____ Blood Clotting Problems

_____ Other

If other, please list: ____

Current Prescription Medications:

Medication Name: Strength: Date Started: How often per day:

____

Last Name: ______________

____

____

____

List hormones previously taken: Date Started: Date Stopped: Reason:

____

____

____

Over the Counter (OTC) Issues: Please check all products that you use occasionally or regularly.

________ Pain Reliever

________ Aspirin

________ Acetaminophen (ex. Tylenol®)

________ Ibuprofen (ex. Motrin IB®)

________ Naproxen (ex. Aleve®)

________ Ketoprofen (ex. Orudis KT®)

________ Cough Suppressant (ex. Robitussin DM®)

________ Antihistamine product (ex. Chlor- Trimeton®)

________ Decongestant product (ex. Sudafed®)

________ Combination cough +cold reliever (ex. Triaminic®)

________ Sleep aids (ex. Excedrin PM®, Unisom®, Sominex®)

________ Antidiarrheals (ex. Imodium®, PeptoBismol®, Kaopectate®)

________ Laxatives/ Stool Softeners (ex. Doxidan®, Correctol®)

________ Diet Aids/ Weight loss products (ex. Dexatrim®)

________ Antacids (ex. Maalox®, Mylanta®)

________ Acid Blockers (ex. Tagamet HB®, Pepcid AC®, Zantac 75®)

________ Others

If others, please list: ____

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

________ Vitamins (ex. Multiple or single vitamins such as B complex, E, C, Beta Carotene)

________ Minerals (ex. Calcium, magnesium, chromium, colloidal minerals, various single minerals)

________ Herbs (ex. Ginseng, Gingko Biloba, Echinacea, other herbal medicinal tests, tinctures, remedies, etc.)

________ Enzymes (ex. Digestive formulas, papaya, bromelain, CoEnzyme Q10, etc.)

________ Nutritional/ protein supplements (ex. Shark cartilage, protein powders, amino acids, fish oil, etc.)

________ Others (ex. Glucosamine, etc.)

Have you had any of the following tests performed? Please check those that apply and note the date of the last test.

Digital Rectal Exam (DRE)	No: _________	Yes: ___________	Date: _______________	Results: _____________
Cholesterol Level	No: _________	Yes: ___________	Date: _______________	Results: _____________
Prostate Specific Antigen (PSA)	No: _________	Yes: ___________	Date: _______________	Results: _____________
Blood Pressure	No: _________	Yes: ___________	Date: _______________	Results: _____________
Blood Glucose	No: _________	Yes: ___________	Date: _______________	Results: _____________
Do you use tobacco?	No: _________	Yes: ___________	How often/ How much? _____________________	
Do you use alcohol?	No: _________	Yes: ___________	How often/ How much? _____________________	
Do you use caffeine?	No: _________	Yes: ___________	How often/ How much? _____________________	

Do you get routine physical exercise? No: ___________ Yes: ___________ What type? _______________________

Meal Choices:

Breakfast: ____

Lunch: ____

Dinner: ____

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

_________ Prostate Cancer Family Member(s): ____

_________ Testicular Cancer Family Member(s): ____

_________ Other Cancer (type) Family Member(s): ____

_________ Breast Cancer Family Member(s): ____

_________ Heart Disease Family Member(s): ____

_________ Osteoporosis Family Member(s): ____