BREEN
FAMILY MEDICINE

Male Hormone Replacement Therapy Questionnaire

NAME: _____ Todays date: _____

DOB: _____ Age: _____ Last Physical/Blood test: _____

Please list your main symptoms and concerns:

_____

_____

_____

What are your goals for therapy?

1._____

2._____

3._____

Personal Medical History: (check all that apply)

	Heart disease		Bacterial/viral/fungal infections		Celiac disease
	High blood pressure		Arthritis		Blood disease
	High cholesterol		Headaches		Alzheimer's disease
	Diabetes		Depression		Liver disease
	Cancer		Anxiety		Neurological disorders
	Thyroid disorders		Fibromyalgia		Altered Mood Changes
	Osteoporosis		Gastric reflux		Skin disorders
	Asthma/COPD		IBS/Ulcerative colitis/Crohn's		Autoimmune disease
	Migraine headaches		Allergies (pets/seasonal/food)		Anemia

Family medical history: Has anyone in your family has any of the following?

□Heart Disease Relationship: _____
□High Blood Pressure Relationship: _____
□Cancer (type) Relationship: _____
□Stroke Relationship: _____
□Diabetes Relationship: _____
□Renal Disease Relationship: _____
□Osteoporosis Relationship: _____
□High Cholesterol Relationship: _____

Hormone Therapy History:

Are you currently or have you ever had Hormone Replacement Therapy? □YES □NO

If yes, what type of hormones?

□Testosterone □DHEA-S □Thyroid □Cortisol

Hormone related symptoms: (check all that apply)

	Decreased sex drive		Irritability		Loss of muscle mass
	Decreased energy/fatigue		Decrease height		Sleep disturbances
	Nervous		Breast enlargement		Mood changes
	Foggy thinking		Depression		Sadness/Unhappiness
	Cold body temperature		Erection difficulty		Hair loss/thinning
	Weight gain		Prostate enlargement		Increase abdominal weight
	Frequent sleepiness		Decreased mental sharpness		Decreased work performance

Want more children? □YES □NO

Last Prostate exam _____ Last PSA _____ Normal / Elevated (circle one)

Past surgeries: (Type/date): _____

_____

Medical factors possibly affecting treatment: (check all that apply)

	I have had testicular or prostate cancer		I have trouble passing urine or take Flomax or Avodart
	I have prostate cancer in my family		I have/had a blood clot &/or pulmonary embolism
	I have an elevated PSA		I have has a stroke &/or heart attack
	I am at least 20 pounds overweight		I have chronic liver disease (e.g. hepatitis, fatty liver, cirrhosis)
	I have elevated lipids &/or cholesterol lowering medication		

Social History: (check all that apply)

	I smoke cigarettes (how many:_____/day)		I drink more than 10 drinks of alcohol per week
	I am a recovering alcoholic		I use or have used marijuana in the last year
	I use cocaine or other illicit drugs		I regularly take opiates

Patient Signature_____ Date_____

Provider Signature_____ Date_____

To be completed by office staff

Colonoscopy Exam received □YES □NO

Bone Density Exam received □YES □NO