

INSTRUCTIONS:

This PDF file can be downloaded to your computer or printed on your printer in order to be completed by hand and brought with you to your appointment. If you can scan the completed form, you can email it to **drjoffice@yahoo.com**. Be sure to include your full name in the body of your email.

Should you have any questions, please contact us at **325.698.8500**.

Thank You!





Weight & Hormone Clinic
MALE MEDICAL HISTORY

Any known drug allergies?

Have you ever had any issues with anesthesia? ☐ YES ☐ NO

If yes, please explain

Medications currently taking

Current hormone replacement therapy

'Past hormone replacement therapy

Nutritional/Vitamin Supplements

Surgeries [list all & when]

Other pertinent information

Medical Illnesses:

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Trouble passing Urine or take Flomax or Arodart
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Chronic Liver Disease [Hepatitis/Fatty Liver/Cirrhosis]
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Stroke and/or Heat Attack	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Blood Clot and/or Pulmonary Embolism	<input type="checkbox"/> Depression / Anxiety
<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Testicular or Prostate Cancer
<input type="checkbox"/> Any form of Hepatitis or HIV	<input type="checkbox"/> Elevated PSA
<input type="checkbox"/> Lupus or any other Auto-Immune Disease	<input type="checkbox"/> Prostate Enlargement
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Cancer [type] <input type="text"/>
	[year] <input type="text"/>
	<input type="checkbox"/> Other <input type="text"/>

I understand that if I begin Testosterone Replacement with any Testosterone Treatment, including Testosterone Pellets, that I will produce less Testosterone from my Testicles and if I stop replacement, I may experience a temporary decrease in my Testosterone production. Testosterone Pellets should be completely out of your system in 12 months.

By beginning treatment, I accept all the risks of therapy stated herein and future risks that might be reported. I understand that higher than normal physiologic levels may be reached to create the necessary hormonal balance.

<input type="text"/>	<input type="text"/>	<input type="text"/>
Print Name	Signature	Today's Date



Weight & Hormone Clinic
HEALTH ASSESSMENT FOR MEN

Name

Date

Email

SYMPTOMS [please check box]	Never	Mild	Moderate	Severe
1] Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2] Mood Changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety / Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3] Decreased Mental Ability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Confusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Focus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4] Excessive Sweating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5] Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Belly Fat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inability to Lose Weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6] Decreased Sex Drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No Morning Erections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7] Sleep Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can't Stay Asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can't Fall Asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8] Decreased Muscle Strength	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9] Hair Loss / Breakage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10] Joint Pain / Muscle Aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FAMILY HISTORY [please check box]	NO	YES
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>



MALE PATIENT QUESTIONNAIRE & HISTORY

Marital Status [Check One] ☐ Married ☐ Divorced ☐ Widower ☐ Living with Partner ☐ Single

Home PPhone Cell Phone Work

☐ I have used steroids in the past for athletic purposes.

☐ I use caffeine ☐ a day.

ADDITIONAL DETAILS



Weight & Hormone Clinic
10 Hospital Drive, Abilene, Texas 79606 // (325) 698-8500