



## 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 and when: \_\_\_\_\_

Other Pertinent Information: \_\_\_\_\_

### Medical Illnesses:

- |  |   |
|--|---|
| <input type="checkbox"/> High blood pressure.                  | <input type="checkbox"/> Testicular or prostate cancer.                             |
| <input type="checkbox"/> High cholesterol.                     | <input type="checkbox"/> Elevated PSA.  |
| <input type="checkbox"/> Heart Disease.                        | <input type="checkbox"/> Prostate enlargement.                                      |
| <input type="checkbox"/> Stroke and/or heart attack.           | <input type="checkbox"/> Trouble passing urine or take Flomax or Avodart.           |
| <input type="checkbox"/> Blood clot and/or a pulmonary emboli. | <input type="checkbox"/> Chronic liver disease (hepatitis, fatty liver, cirrhosis). |
| <input type="checkbox"/> Hemochromatosis.                      | <input type="checkbox"/> Diabetes.  |
| <input type="checkbox"/> Depression/anxiety.                   | <input type="checkbox"/> Thyroid disease.   |
| <input type="checkbox"/> Psychiatric Disorder.                 | <input type="checkbox"/> Arthritis.   |
| <input type="checkbox"/> Cancer (type): _____                  |   |
| Year: _____  |   |

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.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Today's Date

## BHRT Checklist For Men

Name: \_\_\_\_\_

Date: \_\_\_\_\_

E-Mail: \_\_\_\_\_

<b>Symptom (please check mark)</b>	<b>Never</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>
Decline in general well being				
Fatigue				
Joint pain/muscle ache				
Excessive sweating				
Sleep problems				
Increased need for sleep				
Irritability				
Nervousness				
Anxiety				
Depressed mood				
Exhaustion/lacking vitality				
Declining Mental Ability/Focus/Concentration				
Feeling you have passed your peak				
Feeling burned out/hit rock bottom				
Decreased muscle strength				
Weight Gain/Belly Fat/Inability to Lose Weight				
Breast Development				
Shrinking Testicles				
Rapid Hair Loss				
Decrease in beard growth				
New Migraine Headaches				
Decreased desire/libido				
Decreased morning erections				
Decreased ability to perform sexually				
Infrequent or Absent Ejaculations				
No Results from E.D. Medications				

### Family History

	<b>NO</b>	<b>YES</b>
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		