BIO-IDENTICAL HORMONE THERAPY SYMPTOMS

Patient Name: ______________________ Date of Birth: __________ Date: ______________

Please answer the yes or no questions; then go on to the Male or Female questions based on your gender.

Yes	No		Severity if yes (Mild, Moderate, Severe		
☐	☐	Decreased sense of well-being	☐ Mild	☐ Moderate	☐ Severe
☐	☐	Thinning or loss of hair	☐ Mild	☐ Moderate	☐ Severe
☐	☐	Difficulty sleeping	☐ Mild	☐ Moderate	☐ Severe
☐	☐	Heat or cold intolerance	☐ Mild	☐ Moderate	☐ Severe
☐	☐	Decreased energy	☐ Mild	☐ Moderate	☐ Severe
☐	☐	Decreased skin tone	☐ Mild	☐ Moderate	☐ Severe
☐	☐	Decreased concentration, memory	☐ Mild	☐ Moderate	☐ Severe
☐	☐	Mood swings	☐ Mild	☐ Moderate	☐ Severe
☐	☐	Decreased sex-drive	☐ Mild	☐ Moderate	☐ Severe
☐	☐	Sadness, depression	☐ Mild	☐ Moderate	☐ Severe
☐	☐	Decreased muscle strength	☐ Mild	☐ Moderate	☐ Severe
☐	☐	Hot flashes	☐ Mild	☐ Moderate	☐ Severe
☐	☐	Increased fat deposits	☐ Mild	☐ Moderate	☐ Severe
☐	☐	Prolonged exercise healing	☐ Mild	☐ Moderate	☐ Severe

☐ ☐ Have you ever been on hormone therapy before? If yes, please explain ______________________

☐ ☐ Are you on current hormone replacement therapy? If yes, please explain ______________________

☐ ☐ Have you ever been on a testosterone program? If yes, please explain ______________________

☐ ☐ Do you have a stent in your heart vessels? If so when were they placed? ______________________

☐ ☐ Have you ever had a stroke? If yes, please explain ______________________

☐ ☐ Have you ever had any issues with anesthesia? If yes, please explain ______________________

MEN ONLY

Yes	No		Severity if yes (Mild, Moderate, Severe)		
☐	☐	Do you have shrinking Testicles?	☐ Mild	☐ Moderate	☐ Severe
☐	☐	Do you have decrease in beard growth?	☐ Mild	☐ Moderate	☐ Severe
☐	☐	Do you decreased morning erections?	☐ Mild	☐ Moderate	☐ Severe
☐	☐	Do you have infrequent or absent ejaculations?	☐ Mild	☐ Moderate	☐ Severe
☐	☐	Do you have prostate cancer?			

MEN ONLY – CONT.

How many times do you empty your bladder at night? ______ Has this changed in the last 12 (twelve) months? ______________

Have you had a kidney, bladder, or prostate infection in the last 12 (twelve) months? ______________

Do you have blood in your urine? ______________

Date and result of last PSA test: ______________

Do you have problems with erectile dysfunction or ejaculation? ______________

Have you had no results from E.D. medications? ______________

Social (check off)

- ☐ I am sexually active.
- ☐ I want to be sexually active.
- ☐ I have completed my family.
- ☐ I have used steroids in the past for athletic purposes.

WOMEN ONLY

Date of last menses: ______________ Number of pregnancies: ____________ Number of live births: ____________

Are you pregnant or breast-feeding? ______________

Birth Control Method:
Abstinence / Birth Control Pills / IUD / Hysterectomy / Menopause / Tubal Ligation / Vasectomy / Other: ____________

What are your main PMS symptoms? ______________

Most recent mammogram and results: ______________

Most recent pap smear and results: ______________

Most recent bone density and results: ______________

Yes	No		Severity if yes (Mild, Moderate, Severe)		
☐	☐	Do you have vaginal dryness?	☐ Mild	☐ Moderate	☐ Severe
☐	☐	Do you have difficult to climax sexually?	☐ Mild	☐ Moderate	☐ Severe
☐	☐	Do you have breast cancer?			
☐	☐	Have you had a Hysterectomy? If yes, circle if	Total hysterectomy / Partial hysterectomy / Radical hysterectomy		

Social (check off)

- ☐ I am sexually active.
- ☐ I want to be sexually active.
- ☐ I have completed my family.
- ☐ My sex has suffered.
- ☐ I haven't been able to have an orgasm.