CBJR WELLNESS

Male Patient Questionnaire & History

Name: ____Today's Date: ____________
(Last) (First) (Middle)

Date of Birth: ______________ Age: ________ Occupation: ____

Home Address: ____

City: ____ State: __________ Zip: _______________

Home Phone: ______________________ Cell Phone: ______________________ Work: _____________________

E-Mail Address: ____ May we contact you via E-Mail? ( ) **YES** ( ) **NO**

In Case of Emergency Contact: _________________________________ Relationship: ______________________

Home Phone: ______________________ Cell Phone: ______________________ Work: _____________________

Primary Care Physician's Name: ____________________________________ Phone: _______________________

Address: ____
Address City State Zip

Marital Status (check one): ( ) Married ( ) Divorced ( ) Widow ( ) Living with Partner ( ) Single

In the event we cannot contact you by the mean's you've provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Spouse's Name: _______________________________________ Relationship: _____________________________

Home Phone: ______________________ Cell Phone: ______________________ Work: _____________________

Social:

( ) 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.

Habits:

( ) I smoke cigarettes or cigars _______________________ a day.
( ) I drink alcoholic beverages _______________________ per week.
( ) I drink more than 10 alcoholic beverages a week.
( ) I use caffeine _______________________ a day.

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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:

( ) High blood pressure.
( ) High cholesterol.
( ) Heart Disease.
( ) Stroke and/or heart attack.
( ) Blood clot and/or a pulmonary emboli.
( ) Hemochromatosis.
( ) Depression/anxiety.
( ) Psychiatric Disorder.
( ) Cancer (type): ____________________________
Year: ______________

( ) Testicular or prostate cancer.
( ) Elevated PSA.
( ) Prostate enlargement.
( ) Trouble passing urine or take Flomax or Avodart.
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis).
( ) Diabetes.
( ) Thyroid disease.
( ) Arthritis.

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**

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BHRT CHECKLIST FOR MEN

Name: ______________________ **Date:** ______________

Symptom *(please check mark)*	Never	Mild	Moderate	Severe
Decline in general well being				
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				

Other symptoms that concern you: