



CONFIDENTIAL HORMONE EVALUATION - MALE

Today's Date: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____ City _____ State: _____ Zip: _____

Phone: _____ Cell: _____ E-Mail Address: _____
(Please indicate with an * which way you would like us to contact you)

Doctor's Name: _____ Address: _____ Phone: _____

Allergies: Please check all that apply

- | | | | |
|-------------------------------------|---|---|---|
| <input type="checkbox"/> penicillin | <input type="checkbox"/> morphine | <input type="checkbox"/> dye allergies | <input type="checkbox"/> pet allergies |
| <input type="checkbox"/> codeine | <input type="checkbox"/> aspirin | <input type="checkbox"/> nitrate allergy | <input type="checkbox"/> seasonal allergies |
| <input type="checkbox"/> sulfa drug | <input type="checkbox"/> food allergies | <input type="checkbox"/> no known allergies | |

Other: _____

Please describe the allergic reaction: _____

Medical Conditions/Diseases: Please check all that apply to you.

- | | |
|--|---|
| <input type="checkbox"/> heart disease (example: congestive heart failure) | <input type="checkbox"/> blood clotting problems |
| <input type="checkbox"/> high cholesterol | <input type="checkbox"/> high triglycerides |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> depression | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> ulcers | <input type="checkbox"/> headaches/migraines |
| <input type="checkbox"/> hypothyroidism | <input type="checkbox"/> chronic pain |
| <input type="checkbox"/> emphysema | <input type="checkbox"/> hyperthyroidism |
| <input type="checkbox"/> psoriasis | <input type="checkbox"/> COPD |
| <input type="checkbox"/> irritable bowel syndrome (IBS/IBD) | <input type="checkbox"/> Benign Prostatic Hypertrophy (BPH) |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> cancer (type: _____) |
| | <input type="checkbox"/> epilepsy |
| | <input type="checkbox"/> GERD |
| | <input type="checkbox"/> asthma |
| | <input type="checkbox"/> glaucoma |
| | <input type="checkbox"/> fibromyalgia |

PATIENT NAME: _____



Current Medications: Please list all medications you are currently taking. Include prescription medications, over the counter medications, and supplements/herbs.

| Name of Medication | Dose | Times per day | Date Started |
|--------------------|------|---------------|--------------|
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| | | | |

Height: _____ Weight: _____
 BMI (Pharmacist will calculate) _____ (BMI = weight in kg/height in meters²)

BMI results adults over 35:

| | | | |
|---------|-------------|---------|----------------|
| 19-26.9 | Recommended | 30-39.9 | Obese |
| 27-29.9 | Overweight | 40+ | Morbidly Obese |

Waist Circumference: _____ Waist/Hip Ratio: _____
 Hip Circumference: _____

Do you have a family history of any of the following?

- Uterine Cancer _____ Family member(s) _____
- Ovarian Cancer _____ Family member(s) _____
- Fibrocystic breast _____ Family member(s) _____
- Breast Cancer _____ Family member(s) _____
- Heart Disease _____ Family member(s) _____
- Osteoporosis _____ Family member(s) _____
- Colon Cancer _____ Family member(s) _____
- Diabetes _____ Family member(s) _____

Have you had any of the following tests performed? Check those that apply and note date of last test.

PSA _____ No _____ Yes Date: _____

Colonoscopy _____ No _____ Yes Date: _____

PATIENT NAME: _____



Do you smoke? NO _____ YES _____ – how much and for how long _____
How many caffeinated beverages do you drink per day? _____
Portion size _____
How much water do you drink per day? _____ Portion size _____
How many alcoholic beverages do you consume in an average week?

How many meals a day do you eat? _____
Please describe your:
Typical breakfast: _____

Typical lunch: _____

Typical dinner: _____

Do you have trouble waking up in the mornings? _____ No _____ Yes
Do you take naps during the day? _____ No _____ Yes
Do you have trouble falling asleep at night? _____ No _____ Yes
Do you have trouble staying asleep? _____ No _____ Yes
Comments about sleep patterns: _____

Do you work outside the home? _____ No _____ Yes
How many hours per week? _____
Do you enjoy your job? _____
Do you find your job stressful? _____
Do you find your job satisfying? _____
Do you take care of small children, elderly, or disabled adults? _____ No _____ Yes
If Yes, explain: _____

Do you have a hobby? _____ No _____ Yes
What activity relaxes you? _____
How often are you able to do this activity? _____
Is there a place in your home that you can go to relax and be alone?
____No ____Yes
Do you belong to a social or activity group outside of your family?
____ No ____ Yes
Do you have a current exercise routine?
____No____ Yes
If Yes, what kind of exercise and how often per week: _____

PATIENT NAME: _____



Please rate the following symptoms in severity from 0 to 3, 0 being absent and 3 being severe.

- Fatigue _____
- Decrease in Physical Stamina _____
- Erection or Potency Problems _____
- Loss of early morning erection _____
- Anxiety _____
- Depression _____
- Decreased libido _____
- Foggy Thinking _____
- Loss of Memory _____
- Irritability _____
- Trouble Sleeping _____
- Sugar Craving _____
- Morning Fatigue _____
- Evening Fatigue _____
- Arthritis _____
- Bone Loss _____
- Dry Skin _____
- Dry/Brittle Hair _____
- Dry/Brittle Nails _____
- Hair Loss _____
- Constipation _____
- Weight Gain - Hips _____
- Weight Gain – Waist _____

Symptom Numerical Total _____

How did you arrive at the decision to consider Bio-Identical Hormone Replacement Therapy?

Doctor _____ Self _____ Friend/Family Member _____ Other _____

PATIENT NAME: _____



What are your goals with taking BHRT?

Please write down any questions you have about BHRT or this form.

PATIENT NAME: _____



LIFE STRESS TEST

In a now-famous American study from 1967, Dr. Thomas H. Holmes and Dr. Richard H. Rahe created a do-it-yourself stress test. They examined the stress - measured the Life Changes (LCU) . that induced by experiences ranging from death of a spouse to getting a traffic ticket. By adding the LCU values of the past year, you can predict the likelihood of stress related illness or accident.

CHANCE OF ILLNESS OR ACCIDENT WITHIN 2 YEARS.

Total LCU below 150 . 35%
Total LCU between . 150 to 300 . 51%
Total LCU over 300 . 80%

- | | |
|--|--|
| <ul style="list-style-type: none"> _____ Death of Spouse - 100 _____ Divorce . 73 _____ Marital Separation . 65 _____ Jail Term . 63 _____ Death of close family member . 63 _____ Personal injury or illness . 53 _____ Marriage . 50 _____ Fired from work . 47 _____ Marital reconciliation . 45 _____ Retirement . 45 _____ Change in family members health . 44 _____ Pregnancy . 40 _____ Sex difficulties . 39 _____ Addition to family . 39 _____ Business readjustment . 39 _____ Change in financial status . 38 _____ Death of close friend . 37 _____ Change to different line of work . 36 _____ Change in number of marital arguments . 35 _____ Mortgage or loan over \$10,000 . 31 _____ Foreclosure of mortgage or loan . 30 | <ul style="list-style-type: none"> _____ Change in work responsibilities . 29 _____ Trouble with in-laws . 29 _____ Outstanding personal achievement . 28 _____ Spouse begins or stops work . 26 _____ Starting or finishing school . 26 _____ Change in living conditions . 25 _____ Revision of personal habits . 24 _____ Trouble with boss . 23 _____ Change in work hours or conditions . 20 _____ Change in residence . 20 _____ Change in schools . 20 _____ Change in recreational habits . 19 _____ Change in social activities . 18 _____ Mortgage or loan under \$10,000 . 17 _____ Change in sleeping habits . 16 _____ Change in number of family gatherings . 15 _____ Change in eating habits . 15 _____ Vacation . 13 _____ Christmas season . 12 _____ Minor violations of the law . 11 |
|--|--|

_____ **YOUR TOTAL**

This scale shows the kind of life pressure that you are facing. Depending on your coping skills or the lack thereof, this scale may predict the likelihood that you will fall victim to a stress related illness. This illness could be frequent tension headaches, acid indigestion, loss of sleep, to very serious illness like ulcers, cancer and migraines.

Daily practice of relaxation skills is very important for your wellness.

Take care of it now before serious illness erupts or an affliction becomes worse.

PATIENT NAME: _____