

Medical History

Name _____ Date of birth _____ Height _____ Weight _____

Address _____

Tel. _____ Mobile _____ e-mail _____

Medical conditions _____

Current or past hormone therapy _____

Medications _____

Allergies _____

Surgeries/childbirths _____

History of breast or prostate cancer? _____ Last GYN or prostate exam _____

What you want most from this treatment: _____

Check all that apply and rank severity 1 to 10 (worst)

- Fatigue, exertional intolerance _____
- Cold hands and feet _____
- Decreased sweating _____
- Need excessive sleep _____
- Weight gain _____
- Brain fog _____
- Depression _____
- Difficulty falling or staying asleep _____
- Numbness, tingling _____
- Headaches _____
- Constipation _____
- Diarrhea or irritable bowel _____
- Frequent nausea _____
- Heart palpitations or rapid rate _____
- Anxiousness, or panic attacks _____
- Rash _____
- Dry skin _____
- Excessive sweating _____
- Frequent colds and other infections _____
- Low blood pressure, lightheadedness _____
- Low tolerance for stress _____
- Joint or muscle pain _____
- Bladder/urination _____
- Aches and pains _____
- Vision problems _____

Females only, Last period _____

- Heavy blood flow _____
- Irregular periods _____
- Breast swelling, tenderness, or cysts _____
- PMS _____
- Swelling of face, fingers, or ankles _____
- Infertility _____
- Hot flashes or night sweats _____
- Moodiness, cry easily _____
- Painful intercourse _____
- Vaginal dryness or pain _____
- Dry or irritated eyes _____
- Disinterest in sex _____
- Osteoporosis _____
- Facial hair growth _____

Males only

- Apathy, low motivation _____
- Decreased physical stamina _____
- Loss of muscle mass or strength _____
- Joint stiffness _____
- Moodiness, irritability _____
- Decrease in libido _____
- Few or no spontaneous AM erections _____
- Prostate enlargement V
- Increased fat around waist and hips _____