Men's Consultation

Date:_____Referral:_____Email:_____
Name:_____ Home:_____ Cell:_____
Address:_____City:_____State:_____
DOB:_____AGE:_____Martial Status: M W D S Occupation:_____
Reason for Visit: _____
_____

Please check all applicable and explain:

↑ Excessive Weight	↑ Hepatitis	↑ Mental Health/Depression
↑ Chronic Fatigue Syndrome	↑ HIV Positive	↑ Mitral Valve Prolapse
↑ Colitis	↑ Hypertension	↑ Multiple Sclerosis
↑ Diabetes	↑ Hypohyroidism	↑ Elevated Cholesterol
↑ Hypothyroidism	↑ Seizures	↑ Vertigo
↑ Elevated Triglycerides	↑ Kidney Disease	↑ Sleep Disorders
↑ Heart Disease	↑ Irrit. Bowel Syndrome	↑ Skin Complaints

Health Maintenance: (Date last Exam)
Bone Density: _____Physical Exam:_____PSA:_____
Lipid Profile: _____Flex Sigmoidoscopy_____
Td: _____Influenza:_____Pnuemovax:_____
Medical Problems: (Explained from above)_____
_____
_____
Name and number of Primary Care Physician:_____
Current Medications/Supplements:_____
_____
_____
Do you have any drug allergies?↑ No↑ Yes If Yes explain:_____
_____
Do you exercise?↑ No↑ Yes What kind?_____ How Often_____
Do you smoke? ↑ No↑ Yes How much?_____ How Long?_____
Do you use alcohol?↑ No ↑ Yes How much?_____ How Long?_____

Have you had a major illness/hospitalization/surgery?↑ No↑ Yes
Explain:_____
_____

Is there a family history of: (Please check)

↑ Colon Cancer	↑ Prostate Cancer	↑ Diabetes	↑ Lung Cancer
↑ High Blood Pressure	↑ Heart Disease	↑ Other_____	

Are you interested in our other services?

↑ Nutritional testing	↑ Laser Rejuvenation	↑ Weight Management
↑ Allergy Testing	↑ Laser Hair Removal	↑ Massage
↑ Weight Management	↑ Laser Skin Tightening	↑ Laser Hair Regrowth

Family History

		Medical Problem(s)
Father- alive or deceased?	Age _____	_____
Mother- alive or deceased?	Age _____	_____
Brothers/sisters: _____		Medical Problem(s) _____
_____	Age _____	_____
_____	Age _____	_____
_____	Age _____	_____

REVIEW OF SYMPTOMS

Heart

Y N Do you ever feel your heart skip a beat? How often? _____
For how many years? _____

Y N Do you have chest pain? How often? _____
For how many years? _____
Is the pain sharp / stabbing / dull / aching? Does it radiate to your neck, back, or shoulders?

Y N How long does the pain last? _____

Y N Do you feel like you are going to pass out?

Gastrointestinal System

Y N Do you have abdominal cramping, bloating, excessive belching or intestinal gas?
How often? ____ x/week _____ How long? _____

Urinary Tract

Y N Have you ever had bladder infections / kidney infections?
How many x/year? ____ For how many years? _____

Y N Have you ever had kidney stones? How many times? _____
Year of last episode _____

Y N Do you have burning upon urination?

Y N Do you have increased frequency of urination?

Skin

Y N Do you have any unexplained skin rashes or itchy skin?
How long? _____ months _____ years
Do you know the cause of your rashes/itchy skin? _____

Thyroid

Y N Have you been diagnosed with a thyroid disorder? Year diagnosed _____

Y N Were you diagnosed with hyperthyroidism

Y N Were you diagnosed with hypothyroidism

Y N Did you ever take thyroid medication? What year did you quit? _____
Name of medicine _____ Dose _____ mg

Malaise/Fatigue

Y N Do you feel you should have more energy?
What is your average energy level on a scale of 0 to 10 with 10 meaning brimming with energy
and 1 or 2 meaning the inability to get out of bed?
ENERGY LEVEL 0-10 ____ /10 For how many years? _____

Hair Condition

Y N Do you have coarse or fine hair? For how many years? _____

Y N Have you ever had significant hair loss?
How long? _____ months _____ years

Weight

Y N Have you had significant weight gain? How many pounds? _____
Since what year? _____

Y N Do you have difficulty losing weight? How long? _____

Mood

Y N Do you ever feel discouraged, blue or depressed more than 10% of the time?
What percent of the time? _____ % For how many years? _____

Y N Have you ever taken anti-depressants?
Which one(s)? _____
Between what ages? _____ y.o. and _____ y.o.

Skin

Y N Do you have dry skin? For how many years? ___

Sleep

Y N Do you have insomnia or restless sleep? How many years? _____

Y N Do feel tired after a full night's sleep? How many years? _____

Y N Do you have afternoon fatigue?
How many hours of sleep do you require? _____ hours/night?

Male Hormone Checklist

Check applicable symptoms of each category:

Androgen Deficiency

_____Low libido
_____Fatigue
_____Aches/Pains/Arthritis
_____Memory Lapses
_____Incontinence
_____Heart Palpitations
_____Depression
_____Thinning Pubic Hair
_____Decreased Muscle Mass
_____Bone Loss
_____Thinning Skin
_____Fibromyalgia

Androgen Excess

_____*Excessive Facial Hair*
_____*Excessive Body Hair*
_____*Increased Acne*
_____*Breast Cancer*
_____*Elevated Triglycerides*
_____*Oily Skin*
_____*Ovarian Cysts*
_____*Hair Loss scalp*
_____*Nervous/Irritable*

Cortisol Deficiency

_____Fatigue
_____Sugar Cravings
_____Allergies
_____Chemical Sensitivity
_____Stress
_____Cold Body Temp.
_____Irritable
_____Arthritis
_____Heart Palpitations
_____Aches / Pains

Cortisol Excess

_____*Sleep Disturbances*
_____*Bone Loss*
_____*Fatigue*
_____*Weight Gain/Loss*
_____*Muscle Mass Loss*
_____*Thinning Skin*
_____*Elevated Triglycerides*
_____*Breast Cancer*
_____*Irritable*
_____*Anxious*
_____*Memory Lapse*
_____*Heart Palpitation*
_____*Headaches*
_____*Stress*
_____*Cold Body Temp*
_____*Sugar Cravings*
_____*Low Libido*
_____*Hair Loss*
_____*Increased Facial Hair*
_____*Increased Body Hair*
_____*Acne*
_____*Nervous*

Thyroid Deficiency

_____Tired or Exhausted
_____Sad or Depressed
_____Cold Body Temp.
_____Cold Hands & Feet
_____Weight Gain
_____Can't Lose Weight
_____Memory Lapse
_____Forgetfulness
_____Nails breaking/ Brittle
_____Aches / Pains
_____Low Libido
_____Heart Palpitation
_____Sleep Disturbances
_____Bone Loss
_____Decreased Muscle Mass
_____Thinning Skin
_____Difficult to Concentrate
_____Mood Changes
_____Swelling/Puffy eye/face
_____Low Blood Pressure
_____Slow Pulse Rate
_____Decreased Sweating
_____Hair Dry/ Brittle
_____Hair Loss
_____Infertility Problems
_____Slowed Reflexes
_____Constipation
_____Thick Tongue
_____Slow Ankle Reflex
_____Hoarseness