Submit Print Form

Hormone Assessment Patient Information Sheet

Date_____ Patient's Name_____ Phone_____ Cell_____ DOB:_____

Address:_____City_____St_____zip_____

Doctors Name _____Phone _____FAX_____ Insurance #_____

Please answer all the questions below

Have you ever use steroids or hormone replacement Yes___ No___ what did you use(_____)
Are you treated for depression_____if so what are you taking_____
What is your Ht._____ and Wt._____ Do you drink alcohol_____ how much a day_____
How much caffeine do you drink? coffee_____tea_____coke_____ a day. Water____
Do you smoke____ how many packs a day ___. Do you have children? Yes____ No ____
What medication are you taking: _____
_____
What vitamin supplements are you taking?_____
_____
How many days do you exercise a week? 1-2-3-4-5-6-7 what do you do_____

Is there a family history of any cancer and who?
Prostate Cancer_____ Who_____
Colon Cancer _____Who_____
Breast Cancer _____ Who _____
Osteoporosis _____ Who _____
Heart Disease _____ Who_____
High blood pressure_____Who_____

Have you experienced any of the following symptoms recently?

Symptoms	Yes	No	Symptoms	Yes	No
Sleep disruption			**Fatigue**		
Short Term Memory loss			**Weight gain**		
Depression			**Decreased Energy**		
Irritability			**Loss of drive**		
Erectile dysfunction			**Prostate problems**		
Easy to lose erection			**Back pain**		
Premature ejaculation			**Regular stools**		
Decrease sex drive			**Frequent urination**		
Joint Pain			**Hair loss**		
Arthritis			**Loss of muscle mass**		

Do you have any questions for me or comments you would like to share?

_____

_____

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