Date:_______________

Name: (Last, First) ____

Height: ____________Weight: _____________BMI: ____________

B/P: ______________ Pulse: _____________

Waist Circumference: _________________

Male - Chief Complaint

Chief Complaint / Reason for visit:

☐ Fatigue ☐ Decreased Sex Drive (Low Libido) ☐ Erectile Dysfunction ☐ Decreased Muscle Mass ☐ Weight Gain ☐ Mood Concerns

Symptoms began:_________________months/years ago.

Severity of Symptoms: ☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Severe

Symptoms:

- ☐ Decreased Libido
- ☐ Decreased Spontaneous Erection
- ☐ Breast Discomfort
- ☐ Gynecomastia (Enlarged Breast)
- ☐ Unusual Sweating
- ☐ Hot Flashes
- ☐ Loss of Axillary or Pubic Hair
- ☐ Weight Gain
- ☐ Lack of Energy
- ☐ Fall Asleep After Dinner
- ☐ Sleep Disturbances
- ☐ Lost Height
- ☐ Decreased Enjoyment of Life
- ☐ Decreased of Muscle Mass
- ☐ Recent Deterioration of Work Performance
- ☐ Decreased Sports
- ☐ Decreased Strength / Energy
- ☐ Sad, Grumpy or Moody
- ☐ Problems with Memory / Concentration

Medications - Hormone Dietary Supplements:

Are you currently on Hormones? Yes ☐ No ☐

Have you used testosterone in the past? Yes ☐ No ☐

What kind? ☐ Gels/Creams ☐ Injections ☐ Pellets

For how long?____

Why did you stop them?____

____

Did you have any side effects?____

____

Consent to Have Blood Drawn for Treatment / Testing

I authorize the medical staff to obtain a blood sample for determining my testosterone and PSA levels, as well as any additional appropriate laboratory testing as determined in the professional discretion of the medical staff.

________________________________ ________________

Patient Signature Date

Office Staff Only

☐ New Patient Labs ☐ Follow Up Labs