sheffrin men's health
TESTOSTERONE REPLACEMENT • NUTRITION • FITNESS

Health History Questionnaire

Patient Name _____ Date_____ Age _____

Occupation_____

SYMPTOMS OF LOW TESTOSTERONE LEVELS

Decreased Energy ____Yes ____No

Increased Fatigue ____Yes ____No

Muscle Weakness ____Yes ____No

Decrease in Libido ____Yes ____No

Erectile Dysfunction ____Yes ____No

Decreased Attention ____Yes ____No

Memory Loss ____Yes ____No

Moodiness ____Yes _____No

Depression ____Yes ____No

Feeling Unmotivated ____Yes ____No

Poor Sleep Habits ____Yes ____No

Weight Gain ____Yes ____No

Decreased Concentration ___Yes ____No

PERSONAL HEALTH HISTORY

PLEASE CIRCLE ALL THAT APPLY

General: fainting abnormal weight loss depression cancer

Cardiac/Vascular: chest pain congestive heart failure high blood pressure peripheral vascular disease blood clots selling heart disease high cholesterol diabetes mellitus

Respiratory: difficulty breathing allergy bronchitis pneumonia asthma sleep apnea hay fever

Gastrointestinal: diarrhea intolerance to milk products constipation gallbladder disease gall stones liver disease cirrhosis

Genitourinary: change in urinary frequency over active bladder incomplete emptying of bladder on/off urinary stream pain with urination burning sensation with urination infection of kidney urinary tract infection blood in urine prostate enlargement(BPH) prostate cancer

Previous Therapy: had testosterone levels checked used testosterone previously if so for how long

_____

What type? _____ Amount and frequency? _____ When was last dose? _____

Used estrogen blockers HCG

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Primary Care Provider _____ **Date of last visit** _____

Surgical/ Procedure History:

Year _____ Procedure/Reason _____

Year _____ Procedure/Reason _____

SOCIAL HISTORY

Smoking/Tobacco: not smoking current every day smoker cigarettes chew cigars

Alcohol: yes no number of drinks per week _____

Drug Use: yes no

Exercise Habits: Sedentary (no exercise) Mild Exercise Occasional Vigorous Exercise Regular vigorous exercise

Describe type of exercise and frequency (resistance training, cardiovascular, number of times per week, etc.,)

_____

_____

Family History: Any family history of prostate cancer? Yes ___ No ___

List your prescribed drugs *and* any over-the-counter drugs, such as vitamins and including pre-work-out supplements, herbals, inhalers:

Drug Name _____ Dosage_____ Frequency _____ Taken For _____

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Drug Name _____ Dosage_____ Frequency _____ Taken For _____

Drug Name _____ Dosage_____ Frequency _____ Taken For _____

Allergies:_____No Known Allergies

Or, List Allergies and Reaction _____

Signature _____ **Date** _____

Name (Print) _____