sheffrin men's health
TESTOSTERONE REPLACEMENT • NUTRITION • FITNESS

# Health History Questionnaire page 1 of 2

BLODD PRESSURE: ___________

Reviewed by:____________

Date_______________

Last Name ________________________________ First Name _________________________________ Age ___________

Date of Birth _____/_____/_______ Occupation _________________________ Employer________________________

## 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 |
| Poor Concentration | ____Yes ____No | Night Shift | ____Yes ____No |

## PERSONAL HEALTH HISTORY – circle ALL that apply

**General**: fainting | abnormal weight loss or gain | depression | cancer

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

**Respiratory**: difficulty breathing | allergy | bronchitis | pneumonia | asthma | sleep APNEA |hay fever| snoring | Use of CPAP or BiPAP?

**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 Hormone Replacement Therapy**: Testosterone levels previously checked ___Yes ___ No

Used testosterone or another androgen previously ___Yes ___ No.

If yes, What type? _______________________ How many cycles and for how long ______________________________

Dose (mg) and frequency (daily/monthly/weekly): _______________________

Date of last dose? ___/____/_____ | Used estrogen blockers? ___Yes ___ No | Used HCG? ___Yes ___ No

**Previous testosterone boosting supplements?** ___Yes ___ No

If yes, What type? _______________________ How many cycles and for how long ______________________________

Dose and frequency (daily/monthly/weekly): ___________________________

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## Health History Questionnaire page 2 of 2

Primary Care Provider ______________________________________ Date of last visit _____/_____/_______

**SURGICAL/ PROCEDURE HISTORY:**

Year ______ Procedure/Reason ________________________________________________

Year ______ Procedure/Reason ________________________________________________

Year ______ Procedure/Reason ________________________________________________

Year ______ Procedure/Reason ________________________________________________

**SOCIAL HISTORY - circle those that apply**

**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 or Sudden Cardiac Death? Yes _____ No _____

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

Drug Name ________________________ Dosage_______ Frequency __________ Treatment for __________________

Drug Name ________________________ Dosage_______ Frequency __________ Treatment for __________________

Drug Name ________________________ Dosage_______ Frequency __________ Treatment for __________________

Drug Name ________________________ Dosage_______ Frequency __________ Treatment for __________________

**ALLERGIES:**

_____ No Known Allergies

Allergies and Reactions: ____________________________________________________________________________

Name (Print) _______________________________ Signature _____________________ Date ________________

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## PROVIDER CONSULT NOTES

**HPI**:____________________________________________________________________________________

____________________________________________________________________________________________

**SYMPTOMS**:_______________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

**NUTRITION**:______________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

**EXERCISE**:_______________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

**STRESS**:_________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

**SLEEP**:__________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

**SCREENING | REFERRALS | RECOMMENDATIONS**: _______________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________