

Male Hormone Assessment Form

Name _____ DOB _____ Date _____

Address _____ City _____ St _____ Zip _____

Home (____)____-____ Cell (____)____-____

Who should we contact in case of an emergency? _____ (____)____-____

How did you hear about MD Transformations?

- Newspaper
- Magazine
- Internet
- Brochure
- Word of Mouth
- Friend or family (name) _____
- Solutions Pharmacy
- MD Transformation Staff member
- Other

Please check the following symptoms you are experiencing:

- Loss of lean muscle mass
- Harder to reach climax
- Loss of erections
- Erectile dysfunction
- Depression
- Sleepless nights
- Loss of energy
- Loss of libido
- Weight gain
- Poor cognitive function

If you have any other comments please explain _____

Date of last exam:

- Prostate exam __/__/__ good report ___yes ___no
- Colonoscopy __/__/__ good report ___yes ___no

Family History – Has anyone on your father's side of the family ever had the following:

- Prostate cancer ___yes ___no Who _____
- Colon cancer ___yes ___no Who _____
- Heart Disease ___yes ___no Who _____
- Diabetes ___yes ___no Who _____

Weight _____ Height _____

PAST MEDICAL HISTORY

- 1. Do you have diabetes? yes no
- 2. Do you have/had hypertension? yes no
- 3. Do you have heart disease? yes no
- 4. Do you have a heart murmur? yes no
- 5. Do you have/had kidney disease? yes no
- 6. Have you ever been treated for psychiatric problems? yes no
- 7. Have you ever had rheumatic fever? yes no
- 8. Do you have mitral valve prolapse? yes no
- 9. Have you ever had a urinary tract infection? yes no
- 10. Have you ever had hepatitis/liver disease? yes no
- 11. Have you ever had varicosities/phlebitis? yes no
- 12. Do you have any thyroid problems? yes no
- 13. Have you had any major accidents? yes no
- 14. Have you ever had any blood transfusions? yes no
- 15. Do you have asthma/lung disease? yes no
- 16. Do you have lupus? yes no
- 17. Do you have arthritis? yes no
- 18. Do you have any Drug Allergies? yes no

If yes, please list:

19. Please list any surgeries (include year):

20. Please list any other hospitalizations (include year & reason):

21. Have you had any anesthesia complications? yes no
 If yes, please explain:

22. Have you ever been anemic? yes no

23. Do you have an Internist or Family or GYN doctor? yes no

Please list name & phone number:

_____ phone: _____
 _____ phone: _____
 _____ phone: _____

24. Have you had your cholesterol checked? yes no

If yes, date last checked? _____

Was it normal? yes no

25. Please list any medications you are currently taking:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

26. Do you have allergies?
If yes, list

SOCIAL HABITS

1. Do you smoke? yes no packs/day _____
2. Do you drink alcohol? yes no daily weekly seldom None
3. Do you use recreational drugs, if so which ones?

Would you like to receive an In office \$50 credit? _____
(When you refer a friend and they receive pellets)