Men's Hypogonadism Health Profile/Questionnaire

Please email completed form to JODY@SPRUCEWOODPHARMACY.COM
MUST BE COMPLETED PRIOR TO CONFIRMED APPOINTMENT

Patient Information

Name: _____ Date: _____

Address: _____

Phone: _____

Date of Birth: _____ Height: _____ Weight: _____

BMI (Pharmacist will calculate): _____ (BMI= Wt. in Kg/Ht. in meters²)

BMI Results for Adults Over 35:

19-26.9	Recommended	30-39.9	Obese
27-29.9	Overweight	40 (+)	Morbidly Obese

Waist Circumference:_____ **Hip Circumference:**_____

Medical & Social History: Please check the following that apply to you.

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Cardiovascular Disease
- ☐ Diabetes Mellitus
- ☐ Osteoporosis
- ☐ Benign Prostatic Hyperplasia
- ☐ Tobacco Use
- ☐ Asthma/COPD
- ☐ Alcohol Use
- ☐ Erectile Dysfunction
- ☐ Insomnia
- ☐ Poor Nutrition
- ☐ Depression/Anxiety
- ☐ Cancer: _____
- ☐ Other: _____

Medication History: List all prescription and non-prescription medications that you are taking. (Include vitamins, herbals and supplements.)

_____

_____

_____

_____

_____

_____

_____

_____

Drug Allergies: _____

_____

_____

Please indicate if you are experiencing the following symptoms:

	NONE	MILD	MODERATE	SEVERE
Do you feel more fatigued/tired than usual?	☐	☐	☐	☐
Have you noticed a decrease in muscle mass?	☐	☐	☐	☐
Have you experienced a loss in muscle strength?	☐	☐	☐	☐
Have you experienced increased joint/muscle pain?	☐	☐	☐	☐
Have you noticed an increase in your waist size?	☐	☐	☐	☐
Do you have difficulty losing weight?	☐	☐	☐	☐
Have you experienced a decrease in your height?	☐	☐	☐	☐
Have you experienced a decreased sex drive?	☐	☐	☐	☐
Have you experienced difficulty in establishing a full erection?	☐	☐	☐	☐
Have you experienced difficulty in maintaining a full erection?	☐	☐	☐	☐
Have you noticed a decrease in spontaneous early morning erections?	☐	☐	☐	☐
Have there been changes in your usual sleep patterns?	☐	☐	☐	☐
Do you feel a decrease in your mental sharpness?	☐	☐	☐	☐
Have you had trouble concentrating?	☐	☐	☐	☐
Do you feel less enjoyment in your personal interests and hobbies?	☐	☐	☐	☐

What is your main symptom or concern that led you to consider BHRT/TRT Therapy?

What are your goals for taking BHRT/TRT Therapy?

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