CONSULTATION FORM

Patient Information

Name

M

Last Name

Date of Birth (mm/dd/yyyy)

Street Address

City

State, Zip Code

Home Phone

Cell Phone

Fax

Email Address

Height

Current Weight

Desired Weight

Goals for Age Management Medicine Consultation

Current Medical Conditions

How would you rate your health compared to that of individuals your own age?

◯ Excellent ◯ Good ◯ Average ◯ Fair ◯ Poor

Overall, how satisfied are you with the current state of your health?

◯ Very satisfied, want to maintain my health
◯ Satisfied, but could do better
◯ Dissatisfied, limited by my current health
◯ Very dissatisfied, need to improve current health

Please go over any details pertaining to the answer above.

Current Nutrition/Herbal Supplements (please be as specific as possible)

Male Hormone Symptom Profile

Please check any of the following symptoms which currently or periodically affect you.

- ☐ Aches and pains
- ☐ Acne
- ☐ Anxiety
- ☐ Arthritis / Stiffness
- ☐ Bladder Symptoms
- ☐ Blood Pressure - Low
- ☐ Blood Pressure - High
- ☐ Body Temperature Low (Below 98 Degrees)
- ☐ Breast Tenderness
- ☐ Breast Size Increased
- ☐ Cold Intolerance
- ☐ Cold Hands and Feet
- ☐ Constipation
- ☐ Decreased Libido
- ☐ Decreased Sense of Sexuality
- ☐ Decreased Sexual Arousability
- ☐ Decreased Morning Erections
- ☐ Depression
- ☐ Diarrhea
- ☐ Drowsiness
- ☐ Dry Skin and/or Hair
- ☐ Erection Problems
- ☐ Fatigue
- ☐ Foggy Thinking
- ☐ Food Cravings
- ☐ Forgetfulness
- ☐ Hair Loss - Scalp
- ☐ Hair Loss - Pubic, Armpit and Body
- ☐ Headaches
- ☐ Heart Palpitation
- ☐ Heat Intolerance
- ☐ Hot Flashes
- ☐ Insomnia / Sleep Disturbances
- ☐ Irritability
- ☐ Mood Swings
- ☐ Muscle Flabbiness / Decreased Size
- ☐ Muscle Weakness
- ☐ Nail Abnormality (Thick, Brittle, Ridged)
- ☐ Night Sweats
- ☐ Nipple Tenderness
- ☐ Osteoporosis
- ☐ Sensitive to Temperature Swings
- ☐ Sweating
- ☐ Temperature Swings
- ☐ Water Retention/Bloating
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Wrinkles