PAGDIN HEALTH
LIVING LONGER BETTER
Dr. G. Pagdin Inc.

Male Bio-Identical Hormone Therapy Questionnaire

Name: _____ Date: _____

Primary concern: _____

Symptom	How long have you been experiencing this?	None	Mild	Moderate	Severe
Dry skin		O	O	O	O
Dry hair		O	O	O	O
Cold extremities		O	O	O	O
Insomnia		O	O	O	O
Excessive sleep		O	O	O	O
Low energy/fatigue		O	O	O	O
Memory loss		O	O	O	O
Poor concentration		O	O	O	O
Mood swings		O	O	O	O
Anxiety/nervousness		O	O	O	O
Headaches		O	O	O	O
Depression/sadness		O	O	O	O
Decreased sex drive		O	O	O	O
Difficulty achieving erection		O	O	O	O
Premature ejaculation		O	O	O	O
Muscle pain/weakness		O	O	O	O
Muscle loss		O	O	O	O
Abdominal weight gain		O	O	O	O
Loss of confidence/masculinity		O	O	O	O
Heart palpitations		O	O	O	O
Poor Bladder Control		O	O	O	O
Cramps/spasms in legs or feet		O	O	O	O
Constipation		O	O	O	O
Diarrhea		O	O	O	O
Hair loss		O	O	O	O
Thinning eyebrows		O	O	O	O

Are you experiencing any other symptoms not listed above? If yes, please explain

_____

_____

_____

09/28/2015

Past Hormone Medications

Please list any prescription or non-prescription medications you have taken to treat hormonal symptoms:

Name and dosage (if known)	Duration of use and approximate time frame	Was it effective? Yes/No

Current Medications

Please list all current non-hormonal medications that you are taking:

Name and dosage (if known)	Duration of use and approximate time frame	Was it effective? Yes/No

Current Supplements

Please list all current supplements that you are taking:

Name and dosage (if known)	Duration of use and approximate time frame	Is it effective? Yes/No

Lifestyle

Do you smoke? O No, never have O No, quite at the age of _____ , started at age _____

O Yes, how often? _____ How long have you smoked? _____

How often do you drink alcohol? _____ Alcohol type(s):_____

How often do you exercise? _____ Type(s) of exercise:_____

Do you abide by a special diet? O No O Yes If yes, what type? (Vegan, coeliac, etc.)

_____

_____

What is your marital status? _____

What are your living arrangements? O Live alone O Live with partner O Live with dependent children at home
Dependent on other: _____

List any drug and non-drug allergies you have:

_____
_____
_____

List any past surgeries:	Date of surgery:
_____	_____
_____	_____
_____	_____
_____	_____

Past Medical History

- O Heart disease/Heart attack
- O High cholesterol
- O High/low blood pressure
- O Diabetes
- O Thyroid Disease (Grave's/Hashimoto's/Hypo/Hyper/Unknown)
- O Deep vein blood clots
- O Rheumatoid arthritis or other arthritis
- O Stomach ulcers
- O Colon cancer
- O Other: _____
- O Liver disease
- O Kidney Disease
- O Stroke
- O Migraine headaches
- O Asthma/COPD
- O Irritable bowel syndrome
- O Crohn's or ulcerative colitis
- O Celiac Disease

Family History

Illness	Family Member(s)
O Heart attack	
O Stroke	
O Diabetes	
O Colon cancer	
O Prostate cancer	
O Other cancer:	
O Osteoporosis	
O Rheumatoid arthritis	
O Lupus	
O Celiac disease	
O Depression/Anxiety	
O Bipolar disorder	
O Schizophrenia	
O Thyroid problem	

Please fax completed forms to **(250) 717-3220** or scan and e-mail to **info@pagdinhealth.com**

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