PhySlim
Physician Guided Weight Loss & Wellness-

Bioidentical Hormone Replacement Candidate Questionnaire

Name: _____ **Date of Birth:** _____

Personal Medical History:

Have you had a digital rectal exam: Yes or No If yes, date: _____

Have you had a colonoscopy: Yes or No If yes, date: _____

Do you have a history of prostate cancer: Yes or No

Do you have a history of testicular cancer: Yes or No

Do you have a history of penile cancer: Yes or No

Testosterone Replacement Therapy in the past: Yes _____ No _____

If yes, please explain: _____

Please list any additional medical problems/conditions/diagnoses:

_____

_____

Family Medical History:

Prostate/Testicular/Penile Caners:

No _____ Yes _____ Who _____

Other cancers/medical problems:

_____

_____

Medications: Please list any medications including over the counter medicines and any vitamins, herbs, or supplements: _____

_____

Please list any surgeries: _____

Please check all that apply:

___ Nervousness/Anxiety

___ Irritability/Aggressiveness

___ Decreased muscle tone

___ Fatigue/Tire easily

___ Decreased sexual drive

___ Hot flashes

___ Dry skin

___ Dry eyes

___ Cold sensitivity/intolerance

___ Facial/Eye puffiness in the morning

___ Difficulty getting out of bed in the morning

___ Joint stiffness in the morning

___ Often feel depressed

___ Difficulty sleeping

___ Decreased muscle tone

___ Increased belly fat

___ Decreased self-confidence

___ Thinning hair

___ Dry hair

___ Decreased under/pubic hair

___ Hands/Feet often cold

___ Gain weight easily

___ Constipation

___ Losing hair on top of head