Male BHRT Medical History Form

MURFREESBORO BIO RENEW & IV INFUSION CLINIC

Name _____
Last Middle First

Address _____ Height _____ Weight _____ Sex M / F

City _____ State _____ Zip _____ DOB _____ Age _____ Marital Status _____

Phone _____ Email _____ Occupation _____

Allergies:	Medications, OTC, Vitamins:

Medical Conditions/Diseases (Please check all that apply)

_____ Heart disease - Type: _____
_____ High cholesterol or lipids
_____ High blood pressure
_____ Cancer - Type: _____
_____ Diabetes
_____ Thyroid disease
_____ Liver Disease
_____ Osteoporosis
_____ Erectile/Testicular/Prostate Problems - Type: _____
_____ Lung disease (ex: asthma, COPD)
_____ Ulcers
_____ Arthritis or joint problems
_____ Depression
_____ Stroke
_____ Headaches / migraines
_____ Persistent urinary tract infections
_____ Other - Please list: _____

Do you have a history or family history of any of the following?

	Yes	No	Family Member(s)
Prostate Cancer	☐	☐	
Testicular Cancer	☐	☐	

Have you had any of the following procedures / exams?

	Yes	No	Date / Results
PSA	☐	☐	
Prostate Exam	☐	☐	
Colonoscopy	☐	☐	
Vasectomy	☐	☐	
Sexually transmitted infections	☐	☐	

Please answer the following questions

Do you have any children? Yes ☐ No ☐
Do you plan to have more children? Yes ☐ No ☐
Do you currently have a partner who is pregnant and/or breastfeeding? Yes ☐ No ☐
Have you used steroids in the past? Yes ☐ No ☐
Do you currently use steroids? Yes ☐ No ☐
Are you currently sexually active? Yes ☐ No ☐

Do you use any of the following?

	Yes	No	If yes, how often and how much
Alcohol	☐	☐	
Tobacco	☐	☐	
Caffeine	☐	☐	
Soy	☐	☐	
Other	☐	☐	

Do you have trouble starting or maintaining an erection?

☐ Yes ☐ No If yes, have you used any medications for it?

What did you use?

Did it help? If no, please explain.

Do you use nitrates for chest pain? Yes ☐ No ☐

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Male BHRT Medical History Form

Name _____
Last Middle First

Please answer the following questions

Have you ever used hormone replacement therapy? ☐Yes ☐No

If yes, list medications, dose, directions, and duration of treatment _____

_____

_____

Did you have any problems? If yes, please explain. _____

_____

_____

Do you exercise? ☐Yes ☐No

If yes, please describe your routine. _____

_____

_____

Do you currently follow a special diet? ☐Yes ☐No

If yes, please explain. _____

_____

_____

What are your top three goals for starting Hormone Replacement Therapy?

1. _____

2. _____

3. _____

☐ I am not seeking medical treatment for any body enhancement, body building or performance enhancement of any kind.

☐ I am seeking this treatment for legitimate medical purposes.

Patient Signature _____ Date _____

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