Hormone Evaluation – Male

Name/Date____

I feel completely well ☐ Yes ☐ No
The last time I felt completely well was ________________________________ **OR** ☐ NA
My general health has been good. ☐ Yes ☐ No
If NO:
I have physical health problems ☐ Yes ☐ No
My physical problems are:
Heart Attack ☐ Yes ☐ No Date_________________________
Stroke ☐ Yes ☐ No Date_________________________
Diabetes ☐ Yes ☐ No
Controlled- ☐ Yes ☐ No
How Controlled ☐ Diet
☐ Activity
☐ Pills Name and dose ____
☐ Insulin Name and dose ____
☐ Other ____
I check my blood sugar regularly ☐ Yes frequency ___________________________________
☐ No Why? ___________________________________
Cancer ☐ Yes ☐ No Describe ____
Cancer treatment ☐ Current ☐ Past Describe treatment ____________________________
____
____
Obesity ☐ Yes ☐ No Current weight ________ One year ago ________ Five years ago ___________

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