



## Good Integrative Healthcare LLC

### Men's hormone Medical History Form

Name: First \_\_\_\_\_ Last \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Men's Hormones:** (Mark all symptoms you currently or have recently experienced)

- |   |                           |                          |
|---|---------------------------|--------------------------|
| Do you have a history of prostate disease/enlargement/cancer?           | <input type="radio"/> Yes | <input type="radio"/> No |
| Have you ever had an elevated PSA?                                      | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you have any symptoms of Erectile Dysfunction?                       | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you wake more than once at night to urinate?                         | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you have increased urinary frequency or urgency?                     | <input type="radio"/> Yes | <input type="radio"/> No |
| Have you had any recent loss of muscle mass or weight gain?             | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you have a history of anabolic steroid use?                          | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you have a history of cannabis or other illicit drug use?            | <input type="radio"/> Yes | <input type="radio"/> No |
| Are you currently taking any supplements to increase Free Testosterone? | <input type="radio"/> Yes | <input type="radio"/> No |
| Are you noticing thinning hair?   | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you have a history of severe acne on face, chest or back             | <input type="radio"/> Yes | <input type="radio"/> No |