

Male and Female BHRT Intake Form (Pre/Post Pellet)

Please select your gender: *

- ○ Male
- ○ Female

Please select the answer that best describes your symptoms:

Sleep problems (difficulty falling asleep, difficulty in sleeping through the night, waking up early) *

- ☐ None
- ☐ Mild
- ☐ Moderate
- ☐ Severe
- ☐ Extremely Severe

Anxiety (inner restlessness, feeling panicky) *

- ☐ None
- ☐ Mild
- ☐ Moderate
- ☐ Severe
- ☐ Extremely Severe

Irritability (feeling nervous, inner tension, feeling aggressive) *

- [ ] None
- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Extremely Severe

Physical and mental exhaustion (general decrease in performance, impaired memory, decrease in concentration, forgetfulness) *

- [ ] None
- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Extremely Severe

Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings) *

- [ ] None
- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Extremely Severe

Joint or muscular discomfort (pain in the joints, rheumatoid complaints) *

- [ ] None
- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Extremely Severe

Females Only:

Hot flashes, sweating (episodes of sweating)

- [ ] None
- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Extremely severe

Males Only:

Decline in your feeling of general wellbeing? (general state of health)

- [ ] None
- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Extremely severe

Heart discomfort (unusual awareness of heart beat, heart skipping, heart racing, tightness)

- [ ] None
- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Extremely Severe

Excessive sweating?

- [ ] None
- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Extremely severe

Sexual Problems (change in sexual desire, in sexual activity, and satisfaction)

- [ ] None
- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Extremely Severe

Increase need for sleep? (often feeling tired)

- [ ] None
- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Extremely severe

Bladder Problems (difficulty in urinating, increased need to urinate, bladder incontinence)

- [ ] None
- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Extremely Severe

Nervousness or restless?

- [ ] None
- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Extremely severe

Dryness of Vagina (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)

- [ ] None
- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Extremely Severe

Physical exhaustion/lacking vitality?

- [ ] None
- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Extremely severe

Decrease in muscle strength or mass?

- [ ] None
- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Extremely severe

Feeling that you have passed your peak?

- [ ] None
- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Extremely severe

Feel burnt out, having hit rock bottom?

- [ ] None
- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Extremely severe

Decrease in beard growth?

- [ ] None
- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Extremely severe

Decrease in ability/frequency to perform sexually?

- [ ] None
- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Extremely severe

Decrease in the number of morning erection?

- [ ] None
- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Extremely severe

Decrease in sexual desire/libido?

- [ ] None
- [ ] Mild
- [ ] Moderate
- [ ] Severe
- [ ] Extremely severe

Please share any additional comments about your symptoms you would like to address

Do you have cold hands or feet? *

- ◯ Yes
- ◯ No

Do you have daily bowel movements? *

- ◯ Yes
- ◯ No

Do you have gas, bloating or abdominal pain after eating? *

- ◯ Yes
- ◯ No

Please select your WEEKLY activity level based one this criteria --> Physical activity that accelerates heart rate/ breathlessness *

- ◯ 0-1 days per week (low)
- ◯ 2-3 days per week (average)
- ◯ More than 3 days per week (high)

Please list any prior hormone therapy *

First Name *

Last Name *

Date *

MM/DD/YYYY

Signature *