DR. WOODS
WELLNESS
Weight loss & optimal health for life

Date_____

Men's Health Hormone Self-Assessment

Name_____ DOB_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Email:_____

Do you understand what Biologically Identical Hormone Replacement is? _____

Do you understand the risks involved due to your use of Biologically Identical Hormone Replacement such as myocardial infarction, heart disease, stroke, breast cancer?

What are your goals for Biologically Identical Hormone Replacement? _____

_____

_____

To learn more schedule your consultation with Dr. Woods today!

816-888-5200

Or visit

drwoodswellness.com

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Is Biologically Identical Hormone Therapy Right for you?

Name_____DOB_____

To what degree do you experience the following?

	None	Slightly	Moderate	Severe	Extreme
Fatigue or loss of energy					
Depression, low or negative mood					
Irritability, anger or bad temper					
Anxiety or nervousness					
Lack of motivation					
Loss of memory or concentration					
Impotence/Decreased erections					
Inability to ejaculate					
Dry skin on face or hands					
Weight gain/Increased Abdominal Fat					
Backache, joint pains or stiffness					
Loss of muscle mass/tone					
Decreased Urine Flow					
Increased Urinary Urge					
Sleep Disturbances					
Decreased Libido					
Thinning Hair					
Bone Loss					
Night Sweats					
Brain Fog/Burned out Feeling					
Decreased Stamina					

NAME:

MEDICAL HISTORY

GENERAL HEALTH:

Height_____ Weight_____ Do you exercise, describe:_____

- ☐ Good
- ☐ Fair
- ☐ Poor

Health History:

Cancer (type)_____ Diabetes

Heart Disease High Blood Pressure

Other_____

Surgery: **Date:**

_____ _____
_____ _____
_____ _____

Known Allergies: (Drugs/Food/Pollen) **Reaction:**

_____ _____
_____ _____
_____ _____

Current medications and reason (including vitamins/supplements):

_____
_____
_____

NAME:

MEDICAL HISTORY

Prior hormone replacement therapy: (Include dates)

_____
_____
_____

Do you eat/drink:	Amount per day:
Soy	_____
Caffeine	_____
Alcohol	_____

Are you currently following a special diet? (Gluten Free, Casein Free, Adkins, Paleo, Etc):

_____

Family History:	Relationship:
Cancer (type)	_____
Heart Disease	_____
Diabetes	_____
High Blood Pressure	_____
Other	_____

NOTES AND/OR QUESTIONS:

_____
_____
_____
_____
_____