



**Male Hormone Evaluation History**

Name (As it appears on your OHIP card): \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal: \_\_\_\_\_  
Phone (H): \_\_\_\_\_ (B): \_\_\_\_\_ (C): \_\_\_\_\_  
OHIP# \_\_\_\_\_ DOB: (DD/MM/YYYY) \_\_\_\_\_  
Email: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**I understand and accept the fee schedule of \$100 a year (initial visit being \$150) and the 24-hour cancellation policy of the Taunton Chiropractic and Health Centre.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Medical & Social History* (Please check the following that apply to you):

- |                                                       |                                               |
|-------------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> High Blood Pressure          | <input type="checkbox"/> Alcohol Use          |
| <input type="checkbox"/> High Cholesterol             | <input type="checkbox"/> Erectile Dysfunction |
| <input type="checkbox"/> Cardiovascular Disease       | <input type="checkbox"/> Insomnia             |
| <input type="checkbox"/> Diabetes Mellitus            | <input type="checkbox"/> Malnutrition         |
| <input type="checkbox"/> Osteoporosis                 | <input type="checkbox"/> Depression           |
| <input type="checkbox"/> Benign Prostatic Hyperplasia | <input type="checkbox"/> Cancer: _____        |
| <input type="checkbox"/> Tobacco use                  | <input type="checkbox"/> Other: _____         |
| <input type="checkbox"/> Asthma/COPD                  |                                               |

*Medication History:* List all prescription and non-prescription medications that you are taking. (Include vitamins, herbals and supplements.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Drug Allergies:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Circle Yes or No to the following question. If yes, indicate if Mild, Moderate or Severe.**

- |                                                                                        |            |           |
|----------------------------------------------------------------------------------------|------------|-----------|
| 1. Do you feel more fatigued and/or tired than usual?                                  | <b>YES</b> | <b>NO</b> |
| <b>If yes, circle:      Mild          Moderate          Severe</b>                     |            |           |
| 2. Have you noticed a decrease in your muscle mass?                                    | <b>YES</b> | <b>NO</b> |
| <b>If yes, circle:      Mild          Moderate          Severe</b>                     |            |           |
| 3. Have you experienced a loss in muscle strength?                                     | <b>YES</b> | <b>NO</b> |
| <b>If yes, circle:      Mild          Moderate          Severe</b>                     |            |           |
| 4. Have you experienced an increase in joint and/or muscle pains?                      | <b>YES</b> | <b>NO</b> |
| <b>If yes, circle:      Mild          Moderate          Severe</b>                     |            |           |
| 5. Have you noticed an increase in your waist size?                                    | <b>YES</b> | <b>NO</b> |
| <b>If yes, circle:      Mild          Moderate          Severe</b>                     |            |           |
| 6. Do you have trouble losing weight?                                                  | <b>YES</b> | <b>NO</b> |
| <b>If yes, circle:      Mild          Moderate          Severe</b>                     |            |           |
| 7. Have you experienced a loss in height?                                              | <b>YES</b> | <b>NO</b> |
| <b>If yes, circle:      Mild          Moderate          Severe</b>                     |            |           |
| 8. Do you have a decrease in your sex drive?                                           | <b>YES</b> | <b>NO</b> |
| <b>If yes, circle:      Mild          Moderate          Severe</b>                     |            |           |
| 9. Have you experienced difficulty in establishing and/or maintaining a full erection? | <b>YES</b> | <b>NO</b> |
| <b>If yes, circle:      Mild          Moderate          Severe</b>                     |            |           |
| 10. Have you had a decrease in spontaneous early morning erections?                    | <b>YES</b> | <b>NO</b> |
| <b>If yes, circle:      Mild          Moderate          Severe</b>                     |            |           |
| 11. Have you experienced changes in your usual sleep pattern?                          | <b>YES</b> | <b>NO</b> |
| <b>If yes, circle:      Mild          Moderate          Severe</b>                     |            |           |
| 12. Do you feel a decrease in your mental sharpness?                                   | <b>YES</b> | <b>NO</b> |
| <b>If yes, circle:      Mild          Moderate          Severe</b>                     |            |           |
| 13. Have you had trouble concentrating?                                                | <b>YES</b> | <b>NO</b> |
| <b>If yes, circle:      Mild          Moderate          Severe</b>                     |            |           |
| 14. Do you experience less enjoyment in personal interest and hobbies?                 | <b>YES</b> | <b>NO</b> |
| <b>If yes, circle:      Mild          Moderate          Severe</b>                     |            |           |
| 15. I am _____ years old. I feel _____ years old.                                      | <b>YES</b> | <b>NO</b> |