Aislinn Medical Spa

Male Hormone Therapy Consultation

Patient Name: _____ DOB: _____ Date: _____

Patient Concerns: _____

_____

Patient History:

□ Testicular Cancer
□ Prostate Cancer
□ Relative w/ Prostate/Testicular Cancer
□ BPH
□ Smoker - Current or History
□ Polycythemia
□ High Blood Pressure (Hypertension)
_____ Date of Last PSA Level
_____ Date of Last Annual Exam

□ Atherosclerosis
□ Stroke
□ Taking Blood Thinners
□ Liver Disease
□ Diabetes
□ Pituitary Tumor
□ Current or HX of Blood Clots (Thrombosis)
□ Other _____

Allergies

Medications:

Physical Exam:

B/P: HR: RR: Temp: HT: WT: BMI:

General: _____

HEENT: _____

Neck: _____

Cardiovascular: _____

Respiratory: _____

GI: _____

GU: _____

Musculoskeletal: _____

Neuro: _____

Skin: _____

Diagnosis: _____

Treatment Plan:

Labs: □PSA □Total Testosterone □Sevnsitive Estradiol □CBC □Hepatic Function Panel □IGF

_____

_____

_____

_____

Provider Signature: _____ Date: _____