Name Date

RENOVO Male Hormone Questionnaire

Age ______ Children? ______ Are you desirous of having any children? ________

Are you taking any hormones currently? ________ Or in the past? ________

If yes, what hormones?_______________________

Medical History: Please report any pertinent medical conditions that you have.

____

Document any medications that you are currently taking. Are you taking any blood thinners?

____

Do you have any Allergies to Medicines? Latex Allergies? Tape Allergies? If so, what?

____

Family History. Please report any significant medical conditions, including cancers in your family.

____

When did you have your most recent annual examination? _______________

Have you had a PSA test? ______If so, when was the last one obtained? ___________

Was it normal? __________

Do you have any other concerns you would like us to know about?

____

____

Name Date

RENOVO Male Hormone
CHECKLIST FOR MEN

Symptoms	Never	Mild	Moderate	Severe
Decline in general well being	_______	_______	_______	_______
Joint pain/muscle ache	_______	_______	_______	_______
Excessive sweating	_______	_______	_______	_______
Sleep problems	_______	_______	_______	_______
Increased need for sleep	_______	_______	_______	_______
Irritability	_______	_______	_______	_______
Nervousness	_______	_______	_______	_______
Anxiety	_______	_______	_______	_______
Exhaustion/lacking vitality	_______	_______	_______	_______
Decreased muscle strength	_______	_______	_______	_______
Depressed mood	_______	_______	_______	_______
Feeling you have passed your peak	_______	_______	_______	_______
Feeling burned out/hit rock bottom	_______	_______	_______	_______
Decrease in beard growth	_______	_______	_______	_______
Decrease ability to perform sexually	_______	_______	_______	_______
Decrease morning erections	_______	_______	_______	_______
Decrease desire/libido	_______	_______	_______	_______

Other symptoms you would like us to know

____