Robert D. Wilcox, M.D. **MALE** **J. Michael Morrissey, M.D.**

PLASTIC & COSMETIC
SURGERY CENTER OF TEXAS

972-620-1700

HRT Questionnaire For Male

Patient Name: _____ Date of Birth: _____

How did you hear about hormone replacement therapy?

( ) Another Patient ( ) Books / Articles ( ) Ads ( ) Physician ( ) Other

_____

Have you previously had any type of Hormone Replacement Therapy? ( ) Yes ( ) No

If yes, please explain: _____

Current Lifestyle & Habits

Please describe any dietary restrictions: _____

Common Meal Choices:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Do you exercise? ( ) Yes ( ) No How Often? _____ Type of exercise: _____

Do you use caffeine products? ( ) Yes ( ) No How Often? _____ Type: _____

General Health Evaluation:

Please select the best match for the following questions

I am _____ years old. I feel like I am _____ years old.

Do you feel more fatigued and/or tired than usual?

( ) None ( ) Mild ( ) Moderate ( ) Severe

Have you noticed a decrease in your muscle mass?

( ) None ( ) Mild ( ) Moderate ( ) Severe

Have you experienced a loss in muscle strength?

( ) None ( ) Mild ( ) Moderate ( ) Severe

Have you experienced an increase in joint and/or muscle pains?

( ) None ( ) Mild ( ) Moderate ( ) Severe

Have you noticed an increase in your waste size?

( ) None ( ) Mild ( ) Moderate ( ) Severe

Do you have trouble losing weight?

( ) None ( ) Mild ( ) Moderate ( ) Severe

Have you experience a loss in height?

( ) None ( ) Mild ( ) Moderate ( ) Severe

Have you notice a decrease in your sex drive?

( ) None ( ) Mild ( ) Moderate ( ) Severe

Have you experienced difficulty in establishing and/or maintaining full erections?

( ) None ( ) Mild ( ) Moderate ( ) Severe

Do you have a decrease in spontaneous early morning erections?

( ) None ( ) Mild ( ) Moderate ( ) Severe

Have you experienced changes in your sleep pattern?

( ) None ( ) Mild ( ) Moderate ( ) Severe

Do you feel a decrease in your mental sharpness?

( ) None ( ) Mild ( ) Moderate ( ) Severe

Have you had trouble concentrating?

( ) None ( ) Mild ( ) Moderate ( ) Severe

Do you experience less enjoyment in personal interest and hobbies?

( ) None ( ) Mild ( ) Moderate ( ) Severe

Select the following symptoms as they apply to you over the last **30 day period.**

Fatigue, tiredness, especially in late afternoon/early evening:	( ) None	( ) Mild	( ) Moderate	( ) Severe	( ) Very Severe
Depression, negative mood:	( ) None	( ) Mild	( ) Moderate	( ) Severe	( ) Very Severe
Irritability, anger, bad temper:	( ) None	( ) Mild	( ) Moderate	( ) Severe	( ) Very Severe
Anxiety or nervousness:	( ) None	( ) Mild	( ) Moderate	( ) Severe	( ) Very Severe
Loss of memory, concentration:	( ) None	( ) Mild	( ) Moderate	( ) Severe	( ) Very Severe
Relationship problems with your partner:	( ) None	( ) Mild	( ) Moderate	( ) Severe	( ) Very Severe
Loss of sex drive:	( ) None	( ) Mild	( ) Moderate	( ) Severe	( ) Very Severe
Problem with obtaining an erection:	( ) None	( ) Mild	( ) Moderate	( ) Severe	( ) Very Severe
Problem with maintaining an erection:	( ) None	( ) Mild	( ) Moderate	( ) Severe	( ) Very Severe
Loss of early morning erection:	( ) None	( ) Mild	( ) Moderate	( ) Severe	( ) Very Severe
Dry skin face or hands:	( ) None	( ) Mild	( ) Moderate	( ) Severe	( ) Very Severe
Excessive sweating – day or night:	( ) None	( ) Mild	( ) Moderate	( ) Severe	( ) Very Severe
Backache, joint pains, stiffness:	( ) None	( ) Mild	( ) Moderate	( ) Severe	( ) Very Severe
Heavy drinking – past or present:	( ) None	( ) Mild	( ) Moderate	( ) Severe	( ) Very Severe
Loss of fitness, muscle strength:	( ) None	( ) Mild	( ) Moderate	( ) Severe	( ) Very Severe
Unexplained weight gain, mainly in the midsection:	( ) None	( ) Mild	( ) Moderate	( ) Severe	( ) Very Severe
Decrease in initiative, drive:	( ) None	( ) Mild	( ) Moderate	( ) Severe	( ) Very Severe
Falling asleep much earlier than in the past:	( ) None	( ) Mild	( ) Moderate	( ) Severe	( ) Very Severe
Decrease in competitiveness:	( ) None	( ) Mild	( ) Moderate	( ) Severe	( ) Very Severe
Increase in frequency of urination:	( ) None	( ) Mild	( ) Moderate	( ) Severe	( ) Very Severe

_____ _____

Patient Name Date

_____

Signature