Exam Form

HORMONE THERAPEUTICS

Patient: DOB: Date:

BP: BP: BP: BP: BP: BP: BP:

Allergies:

PMH:

PSH:

MEDS:

SOC:

FMHX:

ROS:

- [ ] Decreased Libido
- [ ] Fatigue
- [ ] Erectile Dysfunction
- [ ] Central Obesity
- [ ] Decreased Mentation (clarity of thought, memory)
- [ ] Weight Gain / Muscle Loss Depression

Physical Exam (check if WNL or “+” for positive and “-” for negative)

- [ ] Gen
- [ ] Skin
- [ ] Heent
- [ ] Central Obesity
  - [ ] Thyroid [ ] Enlarged [ ] Nodules
- [ ] Check
- [ ] Cardio
- [ ] ABD
- [ ] GU
- [ ] MS
  - [ ] Muscular Artrophy
- [ ] Neuro
  - [ ] Reflexes(hypo, hyper)

Physician Name: Phone Number:

Physician Signature: Date: