TRT Check-In

Patient Name_____ Age_____ Ht_____ Allergies _____

□ **YES** □ **NO If yes, please explain** _____

On a scale of 1-10 (10 being best) rate your energy level today _____

Is this better or worse than your initial visit? □ BETTER □ WORSE □ SAME

Date: _____

	YES	NO	SAME
Are you sleeping through the night?	□	□	□
If no, is it therapy related? _____			
Any testicle shrinkage?	□	□	□
If yes, _____			
Any tenderness in your nipples?	□	□	□
If yes, _____			
Any erectile dysfunction?	□	□	□
If yes, _____			
Any increase in acne? *(back, neck, arms, etc.)*	□	□	□
If yes, _____			
Any Increase/Decrease in sex drive?	□	□	□
If yes, _____			
Any thinning hair?	□	□	□
If yes, _____			
Emotional Changes? *(aggression, depression, etc.)*	□	□	□
If yes, _____			
Any injection site problems? *(Swelling, soreness)*	□	□	□
If yes, _____			
Any increase in appetite?	□	□	□
If yes, _____			
Are you exercising?	□	□	□
If yes, how much/type? _____			
Are you having any headaches?	□	□	□
If yes, is it therapy related? _____			
Do you have any other concerns?	□	□	
IF YES, _____			
Do you feel you need to see a provider today?	□	□	
IF YES, EXPLAIN _____			

NOTES:

_____

_____

_____

_____

_____

Height:

Weight:

BP:

O2:

HR:

B12:

Testosterone:
Measurements:
Medications:

*****By signing below, you confirm that you have received the medications, injections and/or services as described. *****

Patient Signature: _____

Physician Signature: _____