TRT Check – In

Patient Name: _____ DOB: _____ Date: _____

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

		YES	NO	SAME
1.	Are you sleeping through the night? If No, _____	[ ]	[ ]	[ ]
2.	Any testicle shrinkage? If Yes, _____	[ ]	[ ]	[ ]
3.	Any tenderness in your nipples? If Yes, _____	[ ]	[ ]	[ ]
4.	Any erectile dysfunction? If Yes, _____	[ ]	[ ]	[ ]
5.	Any increase in acne? *(back, neck, arms, ect.)* If Yes, _____	[ ]	[ ]	[ ]
6.	Any increase/decrease in sex drive? If Yes, _____	[ ]	[ ]	[ ]
7.	Any thinning in hair? If Yes, _____	[ ]	[ ]	[ ]
8.	Emotional changes? *(aggression, depression, ect.)* If Yes, _____	[ ]	[ ]	[ ]
9.	Any injection site problems? *(swelling, soreness)* If Yes, _____	[ ]	[ ]	[ ]
10.	Any increase in appetite? If Yes, _____	[ ]	[ ]	[ ]
11.	Are you exercising? If Yes, how much/type? _____	[ ]	[ ]	[ ]
12.	Are you having any headaches? If Yes, is it therapy related? _____	[ ]	[ ]	
13.	Do you have any other concerns? If Yes, _____	[ ]	[ ]	
14.	Do you feel you need to see a provider today? If Yes, _____	[ ]	[ ]	
15.	Are you trying to conceive? If Yes, _____	[ ]	[ ]	
16.	Are you experiencing any pain? If Yes, _____	[ ]	[ ]	

Notes:_____
_____
_____

Weight: _____
BP: _____
HR: _____
O2: _____

Measurements: Arm (R) or (L): _____ Waist: _____
Thigh (R) of (L): _____ Chest: _____
Hips: _____

TESTOSTERONE: _____
HCG: _____
B12: _____
Anastrozole: _____

Patient Signature: _____

Service Provider Signature: _____