ADVANCED HORMONE SOLUTIONS

Male Follow-Up Appointment Sheet

Name: _____

Date: _____

Reason for visit:
- ☐ 30 day follow up
- ☐ 4 month followup
- ☐ Post 12 month

Please mark whether you have had any of the following symptoms:

	Yes	No
Fatigue	☐	☐
Irratability	☐	☐
If yes:		
1 x per week	☐	
2 x per week	☐	
3 or more	☐	
Increase in Memory	☐	☐
Increase in Sexual Desire	☐	☐
Mood Swings		
If yes:		
1 x per week	☐	
2 x per week	☐	
3 or more	☐	
Increase in Energy Level	☐	☐
Anxiety	☐	☐
Muscle Gain/Improved Muscle Tone	☐	☐
Improved Response to Exercise	☐	☐
Improved Recovery to Exercise	☐	☐

	Yes	No
Improved Memory	☐	☐
Mood swings	☐	☐
If yes:		
1 x per week	☐	
2 x per week	☐	
3 or more	☐	
Foggy thinking	☐	☐
Migraines	☐	☐
If yes:		
1 x per week	☐	
2 or more per week	☐	
Weight Loss	☐	☐
Weight Gain	☐	☐
History of Hypertension	☐	☐
Diabetes	☐	☐
Colon Cancer	☐	☐
Testicular Cancer	☐	☐
Prostate Cancer	☐	☐

Please list any questions or concerns you have for the doctor:

_____

_____

_____

_____

For Office Use Only

Vitals

Weight _____

Height _____

BP _____

Temp _____

Clear Form Submit Form