



# Simmon L. Wilcox M.D. - FAAEM (MALE)

## Patient Health & Lifestyle Questionnaire

### PATIENT INFORMATION:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work or Cell Phone: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Gender:  Male  Female  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Occupation: \_\_\_\_\_

### METHOD OF PAYMENT:

Credit Card:  Visa  MasterCard  Check  Other: *(Please Specify Below)*  
 Credit Card Holder: \_\_\_\_\_  
 Credit Card number: \_\_\_\_\_ Expiration Date (mm/yy): \_\_\_\_\_  
 Whom may we thank for your referral? \_\_\_\_\_

**Please Answer All Questions**  
**If you don't know the answer to a required question, simply state that you don't know.**

How did you hear about bioidentical/natural hormone replacement? \_\_\_\_\_  
 \_\_\_\_\_

What are your goals for therapy? \_\_\_\_\_  
 \_\_\_\_\_

### LIFESTYLE INFORMATION:

Do you use tobacco (smoke, chew, dip)?  Yes  No If yes, how often and how much?  
 \_\_\_\_\_

Do you drink alcohol (beer, wine, hard liquor)?  Yes  No If yes, how often and how much?  
 \_\_\_\_\_

Do you drink caffeine (cola drinks, tea, coffee)?  Yes  No If yes, how often and how much?  
 \_\_\_\_\_

Do you exercise regularly?  Yes  No If yes, describe what you do and how often:  
 \_\_\_\_\_

Do you practice any stress management techniques?  Yes  No If yes, describe what you do and how often:  
 \_\_\_\_\_

## DIET: Describe Your Typical Daily Food Intake:

Breakfast: \_\_\_\_\_  
Lunch: \_\_\_\_\_  
Dinner: \_\_\_\_\_  
Other/Snacks: \_\_\_\_\_

Are you currently dieting or using diet pills?  Yes  No

What kind of diet? \_\_\_\_\_

## DOCTOR INFORMATION:

Are you currently under the care of a physician?  Yes  No  
*If yes, please list each doctor from whom you seek care, including address and phone number, if known*

Doctor Name #1: \_\_\_\_\_ Doctor Name #2: \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

**Allergies:** *Please check all that apply*

- |                                   |  |  |   |
|-----------------------------------|--|--|---|
| <input type="checkbox"/> None     | <input type="checkbox"/> Aspirin       | <input type="checkbox"/> Sulfa Drug                  | <input type="checkbox"/> Food Allergies |
| <input type="checkbox"/> Morphine | <input type="checkbox"/> Penicillin    | <input type="checkbox"/> Nitrate Allergy             | <input type="checkbox"/> Dye Allergies  |
| <input type="checkbox"/> Codeine  | <input type="checkbox"/> Pet Allergies | <input type="checkbox"/> Seasonal Allergies (pollen) | <input type="checkbox"/> Other: _____   |

If applicable, please describe any allergic reaction and when it occurred: \_\_\_\_\_

**Over-The-Counter Medications:** *Please check all products that you use occasionally or regularly*

- |   |  |
|---|--|
| <input type="checkbox"/> Pain reliever                          | <input type="checkbox"/> Decongestant (ex: Sudafed®)                               |
| <input type="checkbox"/> Aspirin                                | <input type="checkbox"/> Combination (cough-cold reliever) (ex: Triaminic DM®)     |
| <input type="checkbox"/> Acetaminophen (ex: Tylenol®)           | <input type="checkbox"/> Antihistamine (ex: Chlor-Trimeton®)                       |
| <input type="checkbox"/> Ibuprofen (ex: Motrin IB®)             | <input type="checkbox"/> Sleep aids (ex: Excedrin PM®, Unisom®, Sominex®, Nytol®)  |
| <input type="checkbox"/> Naproxen (ex: Aleve®)                  | <input type="checkbox"/> Diarrhea meds: (ex: Imodium®, Pepto Bismol®, Kaopectate®) |
| <input type="checkbox"/> Ketoprofen (ex: Orudis KT®)            | <input type="checkbox"/> Laxatives/stool softeners (ex: Doxidan®, Correctol®)      |
| <input type="checkbox"/> Cough suppressant (ex: Robitussin DM®) | <input type="checkbox"/> Diet aids/weight loss products (ex: Dexatrim®)            |
| <input type="checkbox"/> Antacids (ex: Maalox®, Mylanta®)       | <input type="checkbox"/> Acid blockers (ex: Tagamet HB®, Pepcid AC®, Zantac 75®)   |
| <input type="checkbox"/> Others (please list): _____            |  |

**Nutritional/Natural Supplements:** *Please identify and list the products you are using:*

- Vitamins (ex: multiple or single vitamins such as B complex, E, C, beta carotene)
  - Minerals (ex: calcium, magnesium, chromium, colloidal minerals, various single minerals)
  - Herbs (ex: Ginseng, Ginkgo Biloba, Echinacea, other herbal medicinal teas, tinctures, remedies, etc.)
  - Enzymes (ex: digestive formulas, papaya, bromelain, CoEnzymeQ10, etc.)
  - Nutrition/protein supplements (ex: shark cartilage, protein powders, amino acids, fish oils, etc.)
  - Others (ex: glucosamine, etc.)
- \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Prescription Medications:**

Medication Name/Dose/# of times daily/# of times /week

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

## TESTS:

Have you ever had any of the following tests performed? Check those that apply and note date of last test.

Prostate exam  Yes  No Date of test and result: \_\_\_\_\_

PSA blood test  Yes  No Date of test and result: \_\_\_\_\_

List details about any abnormal test: \_\_\_\_\_

When did you last have your cholesterol checked? \_\_\_\_\_ Results: \_\_\_\_\_

Do you have any lab test results that you can provide from your last physical with your doctor?  Yes  No

(If yes, please bring copies with you to the appointment or fax to our office)

Have you ever had a bone density scan?  Yes  No If yes, when? \_\_\_\_\_ Results: \_\_\_\_\_

## Hormones:

Are you now or have you ever taken hormones (natural or synthetic) previously? If so please list:

Hormone: \_\_\_\_\_ Date started: \_\_\_\_\_ Date stopped: \_\_\_\_\_

Why: \_\_\_\_\_

Hormone: \_\_\_\_\_ Date started: \_\_\_\_\_ Date stopped: \_\_\_\_\_

Why: \_\_\_\_\_

Hormone: \_\_\_\_\_ Date started: \_\_\_\_\_ Date stopped: \_\_\_\_\_

Why: \_\_\_\_\_

Do you usually get up to urinate during the night?  Yes  No

Any pain with urination?  Yes  No

Any blood in your urine?  Yes  No

Has the force of your urinary stream declined?  Yes  No

Any testicle pain, mass or swelling?  Yes  No

**Family History:** Do you have a family history of any of the following?

Heart Disease  Yes  No Relationship: \_\_\_\_\_

Osteoporosis  Yes  No Relationship: \_\_\_\_\_

Prostate Cancer  Yes  No Relationship: \_\_\_\_\_

Diabetes  Yes  No Relationship: \_\_\_\_\_

## Symptoms:

Please rate the following symptoms: 0 = Rarely a Problem, 1 = Mild, 2 = Moderate, 3 = This is serious for me

____ Constipation	____ Loss of motivation	____ Loss of muscle mass	____ Difficulty Sleeping
____ Difficulty Concentrating	____ Inability to lose weight	____ Joint pains	____ Unable to reach orgasm
____ Loss of hair	____ Moodiness	____ Irritability	____ Can't maintain erection
____ Headache	____ Increase in waist size	____ Difficulty getting erection	____ Foggy Thinking
____ Inability to ejaculate	____ Increase in breast size	____ Low ejaculate volume	____ Memory loss
____ Acne/oily skin	____ Sugar/Food Cravings	____ Low erection quality	____ Low libido
____ Feeling of Depression	____ Anxiety	____ Fatigue	____ Body pain
____ Weight Gain	____ Dry Hair or Skin	____ Increased Body & Facial Hair	____ Backaches

Any other symptoms not listed: \_\_\_\_\_

## MEDICAL HISTORY:

List any medical problems that other doctors have diagnosed:

(ie. heart disease, high blood pressure, blood clots, stroke, liver or kidney problems, diabetes, epilepsy, fibromyalgia, chronic fatigue syndrome, gallstones, depression, hypothyroidism, prostate cancer, breast or other cancers)

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Past Surgeries:

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Past Hospitalizations:

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Do you have treated or untreated high blood pressure?

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Have you ever had a blood transfusion?

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Have you ever had a significant head injury?

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Have you ever had a blood clot of the lower legs or lung?

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Have you ever given yourself street drugs with a needle?

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Please ask any questions you may have about Natural Hormone Replacement Therapy, other medications or nutritional supplements, any other questions that come up as you read through the materials you have received.

Please return the completed questionnaire prior to your appointment. Thank you

Additional Questions:

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RESET FORM

EMAIL FORM