

Patient Intake FormDr. Theo Christodoulakis, www.onegooddoctor.com**Men's Health Care**

602-218-5454

Instructions: please fill in as accurate and as honestly you can.

Name: _____ Age: _____ Date: _____

Are you on Hormonal Therapy (HRT)? _____ Type/when: _____

Ever been on Hormonal Therapy? _____ Ever had been on HRT? _____

Are you on Thyroid Medication? _____ Type/When: _____

Symptoms

	YES	NO
Loss of ability to concentrate	<input type="checkbox"/>	<input type="checkbox"/>
Moodiness and emotionality	<input type="checkbox"/>	<input type="checkbox"/>
Touchiness and irritability	<input type="checkbox"/>	<input type="checkbox"/>
Reduced interest in surroundings	<input type="checkbox"/>	<input type="checkbox"/>
Hypochondria (nagging & complaining)	<input type="checkbox"/>	<input type="checkbox"/>
Reduced intellectual agility (foggy brain)	<input type="checkbox"/>	<input type="checkbox"/>
Great timidity	<input type="checkbox"/>	<input type="checkbox"/>
Feeling weak	<input type="checkbox"/>	<input type="checkbox"/>
Inner unrest	<input type="checkbox"/>	<input type="checkbox"/>
Memory failure	<input type="checkbox"/>	<input type="checkbox"/>
Passive attitudes	<input type="checkbox"/>	<input type="checkbox"/>
General tiredness	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Libido	<input type="checkbox"/>	<input type="checkbox"/>

Additional Indications

Abdominal Fat (central Obesity)	<input type="checkbox"/>	<input type="checkbox"/>
History of Cardio-Vascular disease	<input type="checkbox"/>	<input type="checkbox"/>
History of Hyper-lipidemia	<input type="checkbox"/>	<input type="checkbox"/>
History of Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>
History of Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
History of Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
History of Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
History of Smoking	<input type="checkbox"/>	<input type="checkbox"/>
History of Alcohol overuse (> 2 drinks daily or regular weekend mishaps)	<input type="checkbox"/>	<input type="checkbox"/>

Return this form to the Doctor or Fax/E-mail it:

1-877-240-7608

drchristodoulakis@yahoo.com