



Physician: During initial visit please use this form and return it via fax at 877-410-5522 . Thank You/

Patient \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

BP \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ T \_\_\_\_\_ HT \_\_\_\_\_ WT \_\_\_\_\_ LMP \_\_\_\_\_

Allergies \_\_\_\_\_

PMH \_\_\_\_\_

PSH \_\_\_\_\_

MEDS \_\_\_\_\_

SOC \_\_\_\_\_

FMHX \_\_\_\_\_

ROS (Circle if Positive)

- Decreased Libido
Fatigue
Erectile Dysfunction
Loss of Height
Central Obesity
Weight Change
Decreased Mentation (clarity of thought, memory)
Decreased Strength

Physical Exam (Check if WNL or + for positive and - for negative)

- Gen
Skin
Heent
Thyroid
Chest
Cardio
ABD
GU
Prostate
Testicular
MS
Neuro

Physician Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE FAX TO 877-410-5522 & PLACE BACK IN KIT TO LAB



VITAL SIGNS

Patient Name \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex \_\_\_\_\_

Height :

Weight:

Did you measure client? Yes / No

Did you weigh client? Yes / No

<b>Time</b>	<b>1. Left arm</b>	<b>2. Right arm</b>	<b>Pulse</b>
Systolic			
Diastolic			Irregularities Y / N

Signature of Client \_\_\_\_\_

Signature of Examiner \_\_\_\_\_

DATE: \_\_\_\_\_