

Confidential Male Hormone Evaluation

Pharmacy Solutions
5750 Hidcote Dr Lincoln, NE 68516
Toll Free: 888.890.6521
Fax: 402.486.4286
402.486.3383

Evaluation must be returned at least two days prior to your consult or you may be asked to reschedule your appointment!!

From a clinical management point of view, it is very useful to gain a detailed history of possible hormone deficiencies. The answers provided in the questions below will allow the pharmacist to maintain your medical history and will help in advising about current medical therapies. All information provided will be kept confidential.

Medical History

Name: _____ Birth date: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-mail Address: _____
(primary) (secondary) (optional)

Height: _____ Weight: _____

Your Occupation: _____

Practitioner(s) currently seeing:

Name: _____ Address: _____ Phone: _____

How did you arrive at the decision to consider BHRT?

Doctor Self Friend/Family member Other

Who Referred You?:

Current Medical Conditions:

Allergies: Please check all that apply

___ penicillin ___ morphine ___ dye allergies ___ pet allergies
___ codeine ___ aspirin ___ nitrate allergy ___ seasonal allergies
___ sulfa drug ___ food allergies ___ no known allergies other: _____

Please describe the allergic reaction you experienced and when it occurred.

Over the counter (OTC) medications:

Please check all products that you use occasionally or regularly. Check all that apply.

- | | |
|--|---|
| <input type="checkbox"/> Pain reliever | <input type="checkbox"/> Sleep aids |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Anti-diarrheals |
| <input type="checkbox"/> Acetaminophen (example Tylenol [®]) | <input type="checkbox"/> Laxatives |
| <input type="checkbox"/> Ibuprofen (example Motrin [®] , Advil [®]) | <input type="checkbox"/> Diet Aids/Weight Loss products |
| <input type="checkbox"/> Naproxen (example Aleve [®]) | <input type="checkbox"/> Antacids |
| <input type="checkbox"/> Ketoprofen (example Orudis KT [®]) | <input type="checkbox"/> Acid blockers |
| <input type="checkbox"/> Cough Suppressant (example Robitussin DM [®]) | <input type="checkbox"/> Other (please list) |
| <input type="checkbox"/> Antihistamine product (Benedryl [®]) | _____ |
| <input type="checkbox"/> Decongestant product (Sudafed [®]) | _____ |

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

Vitamins: _____

Minerals: _____

Herbs: _____

Enzymes: _____

Nutritional/Protein Supplements: _____

Others: _____

Current Prescription Medications:

Medication name	Strength	Date started	How often per day
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List Hormones previously taken

Hormone	Date Started/Date Stopped→Reason
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Habits:

Dietary restrictions: _____

Meal Choices: Breakfast: _____

Lunch: _____

Dinner: _____

How often and how much?

Do you use tobacco? Yes No _____

Do you use alcohol? Yes No _____

Do you use caffeine? Yes No _____

How many ounces of water do you drink in a day? _____

What type and how often?

Do you get regular exercise? Yes No _____

How often do you have a bowel movement? _____

Are you fearful of anything? _____

Rank your stress level on a typical day (0-none, 1-mild, 2-moderate, 3-severe) _____

List any major stressors or stressful events in the last 3 to 5 years _____

I am _____ years old. I feel _____ years old.

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

Cholesterol Yes No Date: _____

PSA Yes No Date: _____

Bone Density Yes No Date: _____

Thyroid tested Yes No Date: _____

Testosterone levels Yes No Date: _____

Vitamin D3 Yes No Date: _____

Have any of these test results been abnormal? If YES, please explain. _____

Medical conditions/diseases: Please check all that apply to you.

Heart Disease		High Blood Pressure		Chronic Fatigue	
Stroke		High Cholesterol		Eating Disorder	
Clotting Defect		Diabetes		Thyroid Disease	
Kidney Trouble		Epilepsy		Headaches	
Fractures		Arthritis		Cancer	
Colitis		Gallbladder Trouble		Varicose Veins	
Irritable Bowel		Asthma		Depression	
Ulcers		Autoimmune Disorder		Eye Disease	
Fibromyalgia		Osteoporosis		Others: please list below	

Do you have a family history of any of the following?

Testicular Cancer _____	Family member(s) _____
Prostate Cancer _____	Family member(s) _____
Colon Cancer _____	Family member(s) _____
Urinary Complications _____	Family member(s) _____
Heart Disease _____	Family member(s) _____
Osteoporosis _____	Family member(s) _____
Thyroid _____	Family member(s) _____
Autoimmune _____	Family member(s) _____
Other _____	Family member(s) _____

How many children do you have? _____ Ages of children _____

Are you considering having more children in the future? _____

List any surgeries (example vasectomy) you've had and approximate date(s) _____

What are your goals with taking Bio-Identical Hormone Replacement Therapy or other therapy options?

Do you understand the concept of Bio-Identical Hormone Replacement Therapy? _____

Please write down any questions you have about Bio-Identical Hormone Replacement Therapy?

Patient Symptoms

Rate your current status for each symptom by checking the appropriate modifier. Feel free to use additional space to describe any symptoms. This section may be repeated upon subsequent visits.

Today's Date _____

*** If you mark YES, please rank mild, moderate or severe.**

SYMPTOM	Yes or No	1-Mild	2-Moderate	3-Severe
Fatigued				
Tired				
Depression				
Decrease in muscle mass				
Loss muscle strength				
Increase in joint pain				
Increase in muscle pain				
Increase in waist size				
Trouble losing weight				
Loss in height				
Decrease in sex drive				
Difficulty establishing erection				
Difficulty maintaining erection				
Decrease in spontaneous early morning erections				
Changes in usual sleep pattern				
Decrease in mental sharpness				
Trouble concentrating				