Confidential Male Hormone Evaluation

Pharmacy Solutions
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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: _____________________ (primary) ___________________ (secondary) **E-mail Address:** _______________________ (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.

___ Pain reliever
___ Aspirin
___ Acetaminophen (example Tylenol®)
___ Ibuprofen (example Motrin®, Advil®)
___ Naproxen (example Aleve®)
___ Ketoprofen (example Orudis KT®)
___ Cough Suppressant (example Robitussin DM®)
___ Antihistamine product (Benedryl®)
___ Decongestant product (Sudafed®)

___ Sleep aids
___ Anti-diarrheals
___ Laxatives
___ Diet Aids/Weight Loss products
___ Antacids
___ Acid blockers
___ Other (please list)
____
____

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

List Hormones previously taken

Hormone	Date Started/Date Stopped→Reason

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

Test			
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				