Confidential Male Hormone Evaluation

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To allow enough time to review evaluation, please return at least ***two days*** *prior to your consultation.*

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)

Height: ____________ Weight: ______________

Your Occupation: ____

Practitioner(s) currently seeing:
Name: Address: Phone:

____

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How did you arrive at the decision to consider Bio-Identical Hormone Replacement Therapy (BHRT)?

☐ Doctor ☐ Self ☐ Friend/Family Member ☐ Other

Who Referred You?:

____

Current Medical Conditions:

____

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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.

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____

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 Orudic KT®)
____ Cough Suppressant (example Robitussin DM®)
____ Antihistamine product (example Benadryl®)
____ Decongestant product (example 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: ____
Other: ____

Current Prescription Medications (Star the Medications that have been added within the last 6 months):

Medication Name	Strength	Date Started	How often per day

List Hormones previously taken

Hormone Date Started/Stopped➔Reason

Does anybody else in your household use hormones? ☐ Yes ☐ No

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 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 ever 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 tests 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	

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How many children do you have? _________ Ages of children ______________

Are you considering having more children in the future? ____

List any surgeries (example vasectomy) you have had and approximate date(s): __________________________

____

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What are your goals with taking Bio-Identical Hormone Replacement Therapy?

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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. Please 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 of 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				

SYMPTOM	**Yes or No**	**1 – Mild**	**2 – Moderate**	**3 - Severe**
Difficulty Maintaining Erection				
Decrease in Spontaneous Early Morning Erection				
Changes in Usual Sleep Pattern				
Decrease in Mental Sharpness				
Trouble Concentrating				