



South River
compounding pharmacy

South River Compounding Pharmacy & Wellness Center

2300 Robious Station Circle
Midlothian, VA 23113
Fax: 804-897-6449
(804) 897-6447
www.southernriverRx.com

3656 Mayland Ct
Richmond, VA 23233
Fax: 804-967-6449
Toll Free: 1-888-879-7713
info@southernriverRx.com

General Male Confidential Evaluation

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.

GENERAL INFORMATION

Date: _____

Name: _____ Age: _____ Birth Date: _____

Address: _____

Home Phone: _____ Work Phone: _____

E-Mail: _____

Occupation: _____ Full-time: ___ Part-time: ___ Retired: ___ Unemployed: ___ Other: ___

Living Situation-Spouse: ___ Alone: ___ Partner: ___ Friend(s): ___ Parents: ___ Children: ___ Other: ___

Marital Status- Married: ___ Single: ___ Divorced: ___ Widowed: ___

Pets: _____

How did you hear about South River Compounding Pharmacy? Ad: ___ Another Patient: ___ Courses/
Seminars: ___ Physician/Healthcare Practitioner: ___ Books/Articles/Magazines: ___ Other: _____
Who/Where: _____

What are your goals for the Consultation: _____

PRESCRIPTION INSURANCE

Carrier: _____ ID#: _____

Group#: _____ Relationship to Cardholder: _____

Cardholder Name: _____ Employer: _____

Have you had the following labs drawn recently, if so please list the levels:

Progesterone: _____

Total Estrogen: _____

Testosterone: _____

Sex Hormone Binding Globulin: _____

Thyroid: _____

DHEA: _____

MEDICAL STATUS

General Health- Excellent:____ Good:____ Fair:____ Poor:____ Height:_____

Current Weight:_____ Ideal Weight:_____

Current diagnosis or medical conditions:_____

Drug Allergies:_____

Allergies to food, pollens, etc.:_____

Current Medications:_____

Current Vitamins or OTC products:_____

Current Herbs/etc.:_____

Have you ever had your cholesterol level checked:____ Date:_____ Results:_____

Have you ever had a prostate exam:____ Date:_____ Results:_____

Have you ever had a bone density scan:____ Date:_____ Results:_____

What is your normal Blood Pressure:_____

Current/Recent Health Care Providers:_____

PAST MEDICAL CONDITIONS

Childhood diseases:_____

Heart Trouble:_____ High Blood Pressure:_____ Stroke:_____ Varicose Veins:_____

Clotting Defects:_____ Diabetes:_____ Kidney Trouble:_____ Epilepsy:_____ Fractures:_____

Arthritis:_____ Colitis:_____ Gallbladder Trouble:_____ Asthma:_____ Chronic Fatigue:_____

Fibromyalgia:_____ Eating Disorder:_____ Cancer:_____

HABITS

Dietary Restrictions:_____

Meal Choices-Breakfast:_____

-Lunch:_____

-Dinner:_____

-Snacks:_____

Do you get routine physical exercise:____ What type:_____

Do you use tobacco products:____ How much:____ Previously:____ How long:_____

Do you use alcohol products:____ How much:____ Previously:____ How long:_____

Do you use caffeine products:____ How much:_____

How much water do you drink daily?_____

Stresses (family, work, self, etc.):_____

FAMILY HISTORY

Please list family members and their age which are still living that may have important diseases such as: High Blood Pressure, Heart Disease, Cancer, Diabetes, Osteoporosis, etc.: _____

Please list family members who died of important diseases (see above question) and their age at time of death: _____

SYMPTOMS

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

	Absent	Mild	Moderate	Severe
1. Water Retention, Edema	_____	_____	_____	_____
2. Fatigue, Lack of Energy	_____	_____	_____	_____
3. Loss of Sex Drive	_____	_____	_____	_____
4. Cravings for Sweets	_____	_____	_____	_____
5. Weight Gain	_____	_____	_____	_____
6. Difficulty Staying Asleep	_____	_____	_____	_____
7. Difficulty Falling Asleep	_____	_____	_____	_____
8. Irritability	_____	_____	_____	_____
9. Headaches	_____	_____	_____	_____
10. Frequently Ill	_____	_____	_____	_____
11. Anxiety	_____	_____	_____	_____
12. Depression	_____	_____	_____	_____

- Have unusual fatigue unrelated to exertions?
- Feel chillier than others, often needing to wear socks to bed?
- Dress in layers because of needing to adjust to various temperatures?
- Have feelings of anxiety that sometimes lead to panic?
- Have trouble with weight, often eating lightly, yet still not losing a pound?
- Experience aches/pains in muscles/joints unrelated to trauma or exercise?
- Have increased problems with digestion or allergies?
- Feel mentally sluggish, unfocused, or unusually forgetful?
- Know of anyone in your family who has ever had a thyroid problem?
- Suffer from dry skin, or are prone to adult acne or eczema?
- Go through periods of depression, and/or lowered sex drive?
- Family history of diabetes, anemia, rheumatoid arthritis, early graying hair?
- Experience your hair as feeling like straw, dry and easily falling out?
- Have significant menopausal symptoms or migraine despite estrogen?
- Have a history of whiplash or other neck injuries?
- Have a history of significant exposure to chlorine, bromine, or fluoride?
- Feel utterly exhausted by evening, yet have trouble sleeping?
- Do you wake up tired?

Androgen Deficiency Section

Please put an X in the appropriate box (Yes, No or Don't Know):	Yes	No	Don't Know
Have you ever been diagnosed with low testosterone?			
IF YES, are you being treated for it?			
IF NO:			
Do you have a decreased libido (sex drive)?			
Do you have a lack of energy?			
Do you have a decrease in strength or endurance?			
Have you lost height?			
Have you noticed a decreased "enjoyment of life"?			
Are you sad and/or grumpy?			
Are your erections less strong?			
Have you noticed a recent deterioration in your ability to play sports?			
Are you falling asleep after dinner?			
Has there been a recent deterioration in your work performance?			

SYMPTOMS III

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

	Absent	Mild	Moderate	Severe
13. Energy crashes mid-afternoon	_____	_____	_____	_____
14. Fatigue, Lack of Energy	_____	_____	_____	_____
15. Craving for salty food	_____	_____	_____	_____
16. Exhausted Easily	_____	_____	_____	_____
17. Sensitive to changes in weather	_____	_____	_____	_____
18. Loss of Sex Drive	_____	_____	_____	_____
19. Dark circles under eyes	_____	_____	_____	_____
20. Wounds heal slowly	_____	_____	_____	_____
21. body tender/sensitive to touch	_____	_____	_____	_____
22. Feel puffy/swollen all over	_____	_____	_____	_____

Would you like us to share this information with your physician? _____ YES _____ NO

If yes, please list the doctor's name(s): _____

Date: _____ Signature: _____

Since health information may change periodically, please notify your South River Compounding pharmacist of any new medications (prescription and nonprescription), allergies, drug reactions or health conditions.

Your signature acknowledges your receipt of SRCP's Notice of Privacy Practices according to New Federal Government HIPAA Regulations (This notice describes how medical information about you may be used and disclosed). It does not acknowledge your agreement or any restrictions you may request regarding your Protected Health Information.