

South River Compounding Pharmacy & Wellness Center

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Brief Evaluation - Male

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: _____ Current Health Care Provider _____

What are your health goals?: _____

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: _____ Current Weight: _____ Ideal Weight: _____

Current diagnosis or medical conditions: _____

Current Medications: _____

Current Vitamins or OTC products: _____

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.

| | <u>ABSENT</u> | <u>MILD</u> | <u>MODERATE</u> | <u>SEVERE</u> |
|---------------------------|---------------|-------------|-----------------|---------------|
| Water retention, edema | | | | |
| Frequently ill | | | | |
| Anxiety | | | | |
| Irritability | | | | |
| Depression | | | | |
| Headaches | | | | |
| Difficulty losing gain | | | | |
| Craving for sweets | | | | |
| Difficulty Falling Asleep | | | | |
| Difficulty Staying Asleep | | | | |

- 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.

| | <u>ABSENT</u> | <u>MILD</u> | <u>MODERATE</u> | <u>SEVERE</u> |
|---------------------------------|---------------|-------------|-----------------|---------------|
| Energy crashes mid-afternoon | | | | |
| Fatigue, lack of energy | | | | |
| Craving salty food | | | | |
| Exhausted easily | | | | |
| Sensitive to changes in weather | | | | |
| Loss of sex drive | | | | |
| Dark circles under eyes | | | | |
| Wounds heal slowly | | | | |
| Body tender/sensitive to touch | | | | |
| Feel puffy/swollen all over | | | | |
| Does your mind race at bedtime | | | | |

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.