



South River Compounding Pharmacy, Inc.

2300 Robious Station Circle
 Midlothian, VA 23113
 Fax: 804-897-6449
 Phone: 804-897-6447
www.southernriverrx.com

3656 Mayland Court
 Richmond, VA 23233
 Fax: 804-967-6449
 Toll Free 1-888-879-7713
scheduling@southernriverrx.com

FOLLOW UP MALE EVALUATION FOR 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 us to maintain your medical history and will help in advising about current medical therapies. All information will be kept confidential.

| | |
|--|--|
| P A T I E N T I N S U R A N C E | Date ___/___/___ Name _____ Age _____ Address if new _____ City/State/Zip _____ Home Ph _____ Cell Ph _____ Work Ph _____ Email _____ (only used by SRCP and not sold to other entities) Your primary care MD is _____ Address _____ Tel # _____ ***** IS THERE A CHANGE IN YOUR INSURANCE? Insurance Company _____ ID# _____ Policy Holder _____ Group # _____ Do you have Prescription Insurance – example – Express Scripts, Caremark, Medco ... We will need to obtain a copy of your insurance card. |
|--|--|

At this point in the program, my primary goals and/or chief concerns are:

- 1.
- 2.
- 3.

I complied with the protocol/plan designed for me at the last visit and take my supplements and prescriptions as scheduled:

- Everyday
- 75% of the time
- 50% of the time
- 25% of the time
- Rarely

What challenges or obstacles keep you from following your plan and taking your supplements and prescriptions as scheduled?

I feel that the protocol/plan I've been following has helped me improve:

- by 100%
- by 75%
- by 50%
- 25% or less
- no improvement

NEW SYMPTOMS:

- 1.
- 2.
- 3.
- 4.

HABITS

My appetite is: *circle the most appropriate answer* poor fair good very good out of control

My daily diet usually includes:

| | |
|-----------|--|
| breakfast | |
| snack | |
| lunch | |
| snack | |
| dinner | |
| snack | |

Dietary Restrictions _____

Do you need help with your diet? No Yes

Do you get routine physical exercise? No Yes Type/Frequency/Duration _____

Do you get at least 20 minutes of relaxation each day? No Yes

Do you get a restful nights sleep? Yes No

Do you use tobacco products? Yes No How much _____ Previously _____ How long _____

Do you use alcohol products? Yes No How much _____ Previously _____ How long _____

Do you use caffeine products? Yes No How much _____

How much water do you drink daily? _____

What stressors in your life contribute to your current state of health? _____

CURRENT MEDICAL STATUS

Describe your current health: ___ Excellent ___ Good ___ Fair ___ Poor

Height _____ Current Weight _____ Ideal Weight _____

Current Medications: _____

Current Vitamins/Herbs/OTC: _____

Recent Prostate Exam? Date _____ Results _____

Recent Cholesterol screen? Date _____ Results _____

Recent Bone Density scan? Date _____ Results _____

Recent Blood Pressure? Date _____ Results _____

Recent Blood Glucose? Date _____ Results _____

SYMPTOMS I – Rate each symptom by checking the appropriate modifier. This section is repeated upon subsequent visits to monitor progress.

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

SYMPTOMS II – Check the box if the statement applies to you.

- 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, 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, or early graying hair?
- Experience your hair as feeling like straw, dry and easily falling out?
- Have 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?
- First morning temperature (before your feet hit the floor)? _____

SYMPTOMS III– Androgen Deficiency - Rate each symptom by checking the appropriate modifier. This section is repeated upon subsequent visits to monitor progress.

| Put an X in the appropriate box | Yes | No |
|---|-----|----|
| Have you ever been diagnosed with low testosterone? | | |
| If YES, are you being treated for it? | | |
| If NO: | | |
| Do you have a decreased 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 work performance? | | |

SYMPTOMS IV – Rate each symptom by checking the appropriate modifier. This section is repeated upon subsequent visits to monitor progress.

| | <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 | | | | |
| Mind Racing at Bedtime | | | | |

If you would like us to share this information with your physician, please initial _____

Please list the physician name and phone # _____

Date _____ Signature _____

Your signature acknowledges your understanding of SRCP’s Notice of Privacy Practices according to HIPAA regulations. It does not acknowledge your agreement or any restrictions you may have requested regarding your Protected Health Information.