



South River Compounding Pharmacy, Inc.

2300 Robious Station Circle
Midlothian, VA 23113

3656 Mayland Court
Richmond, VA 23233

Fax: 804-897-6449

Fax: 804-967-6449

Phone: 804-897-6447 Toll Free 1-888-879-7713

www.southernrx.com

scheduling@southernrx.com

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 F O R M A T I O N	<p>Date ___/___/___</p> <p>Name _____ Date of Birth _____ Age _____</p> <p>Address _____</p> <p>Home Ph _____ Cell Ph _____ Work Ph _____</p> <p>Email _____ (only used by SRCP and not sold to other entities)</p> <p><i>Circle all that apply</i></p> <p>Occupation _____ FT PT Retired Unemployed</p> <p>Marital Status - Married Single Divorced Widowed</p> <p>Living Situation - Spouse Alone Partner Friend Parents Children Other</p> <p>Pets - _____</p> <p>Drug allergies/Food allergies/Environmental allergies: _____</p> <p>_____</p> <p>How did you hear about South River Compounding Pharmacy?</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td style="width: 20%;">Advertisement</td> <td style="width: 20%;">Courses/Seminars</td> <td style="width: 20%;">Physician/Practitioner</td> <td style="width: 20%;">Books/Magazines</td> <td style="width: 20%;">Another Patient – who?</td> </tr> <tr> <td style="height: 30px;"></td> <td></td> <td></td> <td></td> <td></td> </tr> </table> <p>Your primary care MD is _____</p> <p>Address _____</p> <p>Tel # _____</p>	Advertisement	Courses/Seminars	Physician/Practitioner	Books/Magazines	Another Patient – who?					
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I N S U R A N C E	<p>Insurance Company _____ ID# _____</p> <p>Policy Holder _____ Group # _____</p> <p>Do you have Prescription Insurance – example – Express Scripts, Caremark, Medco ... We will need to obtain a copy of your insurance card.</p>
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What are your goals for this consultation?

- 1.
- 2.
- 3.

CURRENT MEDICAL STATUS

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

Height _____ Current Weight _____ Ideal Weight _____

Current diagnosis or medical conditions -

Prostate	Diabetes
Erectile dysfunction	High Cholesterol
High blood pressure	Arthritis
Infertility	Other -
Cancer	

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 _____

PAST MEDICAL CONDITIONS

Childhood diseases: _____

Check all boxes that apply

<input type="checkbox"/>	heart disease	<input type="checkbox"/>	varicose veins	<input type="checkbox"/>	kidney trouble	<input type="checkbox"/>	arthritis	<input type="checkbox"/>	asthma	<input type="checkbox"/>	eating disorder	<input type="checkbox"/>	IBS
<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	clotting defects	<input type="checkbox"/>	epilepsy	<input type="checkbox"/>	colitis	<input type="checkbox"/>	chronic fatigue syndrome	<input type="checkbox"/>	thyroid	<input type="checkbox"/>	elevated cholesterol
<input type="checkbox"/>	stroke	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	fractures	<input type="checkbox"/>	gallbladder	<input type="checkbox"/>	fibromyalgia	<input type="checkbox"/>	anemia	<input type="checkbox"/>	cancer

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 gain				
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	<u>Yes</u>	<u>No</u>
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				
Does your mind race 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.