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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.

PATIENT	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 # _________________________________ ____________________________
INSURANCE	** 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 _____________________________

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

	ABSENT	MILD	MODERATE	SEVERE
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)?_________

<u>SYMPTOMS</u> 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 you 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?		

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

	ABSENT	MILD	MODERATE	SEVERE
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.