South River Compounding Pharmacy, Inc.

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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 INFORMATION

Date ___/___/___

Name ______________________________ Date of Birth ___________Age______
Address ____
Home Ph ______________ Cell Ph _______________ Work Ph_______________
Email ____________________________(only used by SRCP and not sold to other entities)

Circle all that apply
Occupation ________________________ FT PT Retired Unemployed
Marital Status - Married Single Divorced Widowed
Living Situation - Spouse Alone Partner Friend Parents Children Other
Pets - ____

Drug allergies/Food allergies/Environmental allergies: _________________________
____

How did you hear about South River Compounding Pharmacy?

Advertisement	Courses/Seminars	Physician/Practitioner	Books/Magazines	Another Patient – who?

Your primary care MD is ____
Address ____
Tel # ____

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.

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

	heart disease		varicose veins		kidney trouble		arthritis		asthma		eating disorder		IBS
	high blood pressure		clotting defects		epilepsy		colitis		chronic fatigue syndrome		thyroid		elevated cholesterol
	stroke		diabetes		fractures		gallbladder		fibromyalgia		anemia		cancer

HABITS

Please List a brief example of a typical day's diet

breakfast	
snack	
lunch	
snack	
dinner	
snack	

Dietary Restrictions ____

Do you get routine physical exercise? ______ Type/Frequency _________________________

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? _________________

Your stresses (family, work, yourself, etc) ____

____

____

FAMILY HISTORY

Indicate family members who are still living with these diseases

	History of Heart Disease	History of Cancer	History of Osteoporosis	History of Diabetes	Other - identify
mother					
father					
sibling					
grandmother					
grandfather					
aunt					

Indicate family members who died of these diseases

Family Member	Age	Heart Disease	Cancer	Other – identify

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 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	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?		

SYMPTOMS 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				
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.

12/2011br