CUSTOM DOSING Rx COMPOUNDING PHARMACY

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Questions Regarding
BioIdentical Hormone Replacement?
Call Us.

BIO-IDENTICAL HORMONE REPLACEMENT

CONFIDENTIAL **MEN'S EVALUATION** FORM

IMPORTANT! FAX or Deliver your Completed form to Custom Dosing Pharmacy at least 1 day in advance of your 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 the pharmacist to maintain your medical history and will in advising about current medical therapies. *All information provided will be kept confidential.*

GENERAL INFORMATION

Date: _____

Name: _____ Age: _____ Birth Date: _____

Street Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Occupation: _____ ☐Full Time ☐Part Time ☐Unemployed ☐Other

Daytime Phone: _____ Evening Phone: _____ Cell: _____

E-Mail Address: _____

Living Situation: ☐Spouse ☐Alone ☐Partner ☐Friend(s) ☐Parents ☐Children ☐Other

Status: ☐Married ☐Single ☐Divorced ☐Widowed

How did you hear about Bio-Identical Hormone Replacement? _____

☐Pharmacy Employee ☐Ad ☐Patient ☐Friend ☐Seminar ☐Physician/Healthcare Referral ☐Book ☐Other

If referred, who referred you? _____

Have you discussed Bio-Identical HRT with you Healthcare Practitioner? _____

Do you understand what Bio-Identical Hormone Replacement Therapy is? _____

What are your 3 main symptoms/concerns?

1 _____ Since when? _____

2 _____ Since when? _____

3 _____ Since when? _____

MEDICAL STATUS

Primary Healthcare Practitioner/Physician: _____ Phone: _____

Physician Address: _____ Fax: _____

Other Physician(s) Currently Seeing: _____

General Health: ☐Excellent ☐Good ☐Fair ☐Poor Height: _____ Weight: _____

Allergies: _____ Blood Type: _____

Bone Density: ☐Yes ☐No Date:_____ Type: ☐Back ☐Hip T-Score:_____

Have you ever had your thyroid tested? ☐Yes ☐No Date:_____ Results:_____

CURRENT AND PAST MEDICAL CONDITIONS

Please check conditions that apply to you.

CONDITION	Y	N	Date of Diagnosis	CONDITION	Y	N	Date of Diagnosis
Heart Disease				High Blood Pressure			
Stroke				Varicose Veins			
Clotting Defects				Diabetes			
Kidney Trouble				Epilepsy			
Fractures				Arthritis			
Colitis				Gallbladder			
Irritable Bowel				Asthma			
Ulcers				Autoimmune Disorder			
Fibromyalgia				Osteoporosis			
Chronic Fatigue				Cancer			
Eating Disorder				Liver Disorders			
Other							

HABITS

Dietary Restrictions:_____

Meal Choices: Breakfast:_____

Lunch:_____

Dinner:_____

Do you get routine exercise? ☐Yes ☐No How Much?_____ How Long?_____

Do you use tobacco products? ☐Yes ☐No How Much?_____ How Long?_____

Do you use alcohol products? ☐Yes ☐No How Much?_____ How Long?_____

Do you use caffeine products? ☐Yes ☐No How Much?_____ How Long?_____

FAMILY HISTORY

LIVING	IMPORTANT DISEASES	LIVING	DECEASED
Mother			
Father			
Brothers			
Sisters			
Aunts			
Uncles			
Paternal Grandmother			
Paternal Grandfather			
Maternal Grandmother			
Maternal Grandfather			

SYMPTOM SHEET

Please Check the Appropriate Boxes Below:

Rate your current status for each symptom by checking the appropriate modifier. Please feel free to use the additional line to describe any symptom. This section may be repeated upon subsequent visits.

	Absent	Mild	Moderate	Severe
Anxious				
Describe:				
Decreased Muscle Size				
Describe:				
Neck or Back Pain				
Describe:				
Sugar Craving				
Describe:				
Ringing in Ears				
Describe:				
Decreased Erections				
Describe:				
Increased Urinary Urge				
Describe:				
Stress				
Describe:				
Slow Pulse Rate				
Describe:				
Thinning Skin				
Describe:				
Hearing Loss				
Describe:				
High Blood Pressure				
Describe:				
Acne				
Describe:				
Difficulty Sleeping				
Describe:				

SYMPTOM SHEET CONTINUED

Please Check the Appropriate Boxes Below:

	Absent	Mild	Moderate	Severe
Mental Fatigue				
Describe:				
Weight Gain Waist				
Describe:				
Prostate Problems				
Describe:				
Night Sweats				
Describe:				
High Cholesterol				
Describe:				
Dry or Brittle Hair				
Describe:				
Constipation				
Describe:				
Hoarsness				
Describe:				
Numbness - Feet or Hands				
Describe:				
Other				
Describe:				
Other				
Describe:				
Other				
Describe:				
Other				
Describe:				
Other				
Describe:				