

Magnolia Pharmacy

CONFIDENTIAL HORMONE EVALUATION - MALE

Today's Date: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ E-Mail Address: _____
(Please indicate with an * which way you would like us to contact you)

Doctor's Name: _____ Address: _____ Phone: _____

Allergies: Please check all that apply

penicillin morphine dye allergies pet allergies
 codeine aspirin nitrate allergy seasonal allergies
 sulfa drug food allergies no known allergies

Other: _____

Please describe the allergic reaction: _____

Medical Conditions/Diseases: Please check all that apply to you.

heart disease (example: congestive heart failure) blood clotting problems
 high cholesterol high triglycerides diabetes
 high blood pressure arthritis cancer (type: _____)
 depression headaches/migraines epilepsy
 ulcers chronic pain GERD
 hypothyroidism hyperthyroidism asthma
 emphysema COPD glaucoma
 psoriasis Benign Prostatic Hypertrophy (BPH)
 irritable bowel syndrome (IBS/IBD) fibromyalgia
 other: _____

PATIENT NAME: _____

Do you smoke? NO _____ YES _____ – how much and for how long _____

How many caffeinated beverages do you drink per day? _____
Portion size _____

How much water do you drink per day? _____ Portion size _____

How many alcoholic beverages do you consume in an average week? _____

How many meals a day do you eat? _____

Please describe your:

Typical breakfast: _____

Typical lunch: _____

Typical dinner: _____

Do you have trouble waking up in the mornings? _____ No _____ Yes

Do you take naps during the day? _____ No _____ Yes

Do you have trouble falling asleep at night? _____ No _____ Yes

Do you have trouble staying asleep? _____ No _____ Yes

Comments about sleep patterns: _____

Do you work outside the home? _____ No _____ Yes

How many hours per week? _____

Do you enjoy your job? _____

Do you find your job stressful? _____

Do you find your job satisfying? _____

Do you take care of small children, elderly, or disabled adults? _____ No _____ Yes

If Yes, explain: _____

Do you have a hobby? _____ No _____ Yes

What activity relaxes you? _____

How often are you able to do this activity? _____

Is there a place in your home that you can go to relax and be alone? _____ No _____ Yes

Do you belong to a social or activity group outside of your family? _____ No _____ Yes

Do you have a current exercise routine? _____ No _____ Yes

If Yes, what kind of exercise and how often per week: _____

Comments: _____

PATIENT NAME: _____

Please rate the following symptoms in severity from 0 to 3, 0 being absent and 3 being severe.

- Fatigue _____
- Decrease in Physical Stamina _____
- Erection or Potency Problems _____
- Loss of early morning erection _____
- Anxiety _____
- Depression _____
- Decreased libido _____
- Foggy Thinking _____
- Loss of Memory _____
- Irritability _____
- Trouble Sleeping _____
- Sugar Craving _____
- Morning Fatigue _____
- Evening Fatigue _____
- Arthritis _____
- Bone Loss _____
- Dry Skin _____
- Dry/Brittle Hair _____
- Dry/Brittle Nails _____
- Hair Loss _____
- Constipation _____
- Weight Gain - Hips _____
- Weight Gain – Waist _____

Symptom Numerical Total _____

How did you arrive at the decision to consider Bio-Identical Hormone Replacement Therapy?

Doctor _____ Self _____ Friend/Family Member _____ Other _____

What are your goals with taking BHRT?

Please write down any questions you have about BHRT or this form.

PATIENT NAME: _____