College Pharmacy
Compounding Specialists

Men's Health Hormone Self-Assessment

Knowledge Changes Everything: Quality | Innovation | Experience | Since 1974

Consulting Pharmacist: _____ Consultation Date: _____

How did you hear about College Pharmacy's Hormone Self-Assessment & Consultation Services?

Advertisement _____ Books/Articles_____

Another Patient _____ Website _____

Healthcare Provider _____ Other (please specify)_____

Personal Information

Patient Name: _____ Date: _____

Address: _____DOB_____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Do you understand what Biologically Identical Hormone Replacement is? _____

Do you understand the risks associated with the use of Biologically Identical Hormone Replacement? _____ **It is recommended that you consult with your physician regarding these risks.*

What are your goals for Biologically Identical Hormone Replacement? _____

_____

_____

Medical History

Family History	**(relationship)**
Cancer (type) _____	_____
Heart Disease	_____
Diabetes	_____
High Blood Pressure	_____
Other	_____

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Medical History

Personal History

- ☐ Heart Disease
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Smoking History
- ☐ Impaired Liver Function
- ☐ Stroke
- ☐ Adult Mumps
- ☐ Prostate Operation
- ☐ Vasectomy
- ☐ Orchitis (testicular inflammation)
- ☐ Cancer (type) _____
- ☐ Persistent Urinary Tract Infections
- ☐ Other Testicular Problems
- ☐ Other _____
- ☐ Other _____

Cholesterol Serum:_____Date:_____ Triglycerides:____ HDL:____ LDL:____ Chol/HDL Ratio:_____

Date of Last Prostate Exam: _____ PSA Results: _____

Current Health Care Provider/s:_____

To what degree do you experience the following?

	None	Slightly	Moderate	Severe	Extreme
Fatigue or loss of energy					
Depression, low or negative mood					
Irritability, anger or bad temper					
Anxiety or nervousness					
Lack of motivation					
Loss of memory or concentration					
Impotence / Decreased erections					
Inability to ejaculate					
Dry skin on face or hands					
Weight gain / Increased Abdominal Fat					
Backache, joint pains or stiffness					
Loss of muscle mass/tone					
Decreased Urine Flow					
Increased Urinary Urge					
Sleep Disturbances					
Decreased Libido					
Thinning Hair					
Bone Loss					
Night Sweats					
Brain Fog/ Burned out Feeling					
Decreased Stamina					

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General Health & Lifestyle

General Health: ☐ Good ☐ Fair ☐ Poor

Height: _____ Weight:_____ Do you exercise, describe:_____

Surgery: **Date of Surgery:**

☐ _____ _____
☐ _____ _____
☐ _____ _____
☐ _____ _____

Current Medications & Reason: _____

_____

_____

Current Vitamins / Minerals / Herbal Formulas: _____

_____

_____

Prior Hormone Replacement Therapy History: (include dates of use) _____

_____

Known Allergies (drug, food, pollen):_____

Are you crrently following a special diet (Gluten Free, Casien Free, Arkins, Paleo, etc):_____

_____

Do you eat/drink soy: _____Caffeine/amount per day:_____ Alcohol/amount per day:_____

Notes and/or Questions:

_____

_____

_____