

Healthway Compounding Pharmacy
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Hormone Consultation for Men

Today's Date: ____/____/____ Birth date: ____/____/____
Patient Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Email: _____

Marital Status Married Single Widowed
Occupation _____
Height: _____ Weight: _____

Allergies: Please check all that apply
 Penicillin morphine dye allergies seasonal (pollen) allergies
 Codeine aspirin nitrate allergy food allergies
 sulfa drugs food allergies pet allergies other: _____

Please describe the allergic reaction you experienced and when it occurred.

Bone Size: Small Medium Large

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

How did you arrive at the decision to consider bio-identical hormone replacement (BHRT)?

Doctor Self Friend/family member Other

Current Prescription Medications/Nutritional Supplements:

(Please bring any nutritional supplements you take to your consultation)

Medication Name	Strength	Date Started	How often per day
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Over-the-counter (OTC) issues: Please check all products that you used occasionally or regularly.

- _____ pain reliever
- _____ sleep aids
- _____ antidiarrheals
- _____ Laxative / stool softener
- _____ Diet aids / weight loss products
- _____ antacids
- _____ others: _____

How often and how much?

- Do you use tobacco? _____ Yes _____ No _____
- Do you use alcohol? _____ Yes _____ No _____
- Do you use caffeine? _____ Yes _____ No _____

Hormones previously taken	Date Started	Date Stopped	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you had any of the following tests performed in the past year? Please check all that apply and note date

- PSA No Yes Date: _____ Normal: Yes No
- Liver Function No Yes Date: _____ Yes No

Have you had a vasectomy? Yes No

Medical Conditions / Diseases: Please check all that apply to you or an immediate family member.

Self	Family		Self	Family	
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol or Lipids
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Eye Disease
<input type="checkbox"/>	<input type="checkbox"/>	Cancer: _____	<input type="checkbox"/>	<input type="checkbox"/>	Migraines/headaches
<input type="checkbox"/>	<input type="checkbox"/>	Clotting Problems	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema/COPD
<input type="checkbox"/>	<input type="checkbox"/>	Fibrocystic breast	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	GERD
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Seizure Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

Please indicate your symptoms for the following conditions by using the following numeric scale:
0 being no symptoms at all up to 5 being the worst symptoms imaginable

Arthritis, Painful Joints	0	1	2	3	4	5
Decrease in Athletic Performance & Competitiveness	0	1	2	3	4	5
Erection Issues	0	1	2	3	4	5
Fatigue, Loss of Energy	0	1	2	3	4	5
Decrease in Mental Sharpness	0	1	2	3	4	5
Decrease in Muscle Mass	0	1	2	3	4	5
Night Sweats / Hot Flashes	0	1	2	3	4	5
Osteoporosis	0	1	2	3	4	5
Short Term Memory Loss	0	1	2	3	4	5
Sleep Disorders, Insomnia	0	1	2	3	4	5
Anxiety	0	1	2	3	4	5
Breasts – Tender, Swollen	0	1	2	3	4	5
Headaches	0	1	2	3	4	5
Increased Irritability, Temper	0	1	2	3	4	5
Mood Swings	0	1	2	3	4	5
Decreased Sex Drive	0	1	2	3	4	5
Weight Gain, Increase in Waist Size	0	1	2	3	4	5
Decreased Urine Flow	0	1	2	3	4	5
Depression	0	1	2	3	4	5
Heartburn/Indigestion	0	1	2	3	4	5
Gas/Bloating	0	1	2	3	4	5
Irritable	0	1	2	3	4	5
Digestive Issues	0	1	2	3	4	5
Age you feel _____						
Age you are _____						

