

Healthway Compounding Pharmacy
2544 McLeod Dr. N., Ste. 2
Saginaw, MI 48604
989-791-1691
Toll Free: 866-883-8868
Fax: 989-791-4603



Hormone Consultation for Men

Today's Date: ____/____/____
Patient Name: _____ Birth date: ____/____/____
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.

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 use once or more per month.

- 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 | <input type="checkbox"/> No <input type="checkbox"/> Yes | Date: _____ | Normal: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Liver Function | <input type="checkbox"/> No <input type="checkbox"/> Yes | Date: _____ | | <input type="checkbox"/> Yes <input type="checkbox"/> 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"/> | Liver Disorder |
| <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 _____						

What are your goals with taking BHRT?

Please write down any specific questions you have about BHRT.

I understand that my hormone consultation at Healthway Compounding Pharmacy is with a pharmacist who specializes in hormone therapy

- Who will NOT diagnose or treat any medical condition,
- Who will NOT replace the advice of my primary care physician in any way,
- Who will work with my referring health care provider to alleviate my hormone related symptoms
- And, who will help me to decide what nutritional supplements, if any, would be safe and appropriate

Name (please print): _____

Signature: _____ Date: _____

Please fax or send this completed questionnaire to:

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