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: _____

Martial 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

			Normal:
PSA	□ No □ Yes	Date: _____	□ 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	
☐	☐	Allergies	☐	☐	Heart Disease
☐	☐	Alzheimer's	☐	☐	High Cholesterol or Lipids
☐	☐	Arthritis	☐	☐	High Blood Pressure
☐	☐	Asthma	☐	☐	Eye Disease
☐	☐	Cancer: _____	☐	☐	Migraines/headaches
☐	☐	Clotting Problems	☐	☐	Osteoporosis
☐	☐	Depression	☐	☐	Thyroid Disease
☐	☐	Diabetes	☐	☐	Ulcer
☐	☐	Eczema	☐	☐	Emphysema/COPD
☐	☐	Fibrocystic breast	☐	☐	Fibromyalgia
☐	☐	Ulcers	☐	☐	GERD
☐	☐	Anxiety Disorder	☐	☐	Seizure Disorder
☐	☐	Stroke	☐	☐	Irritable Bowel
☐	☐	Other: _____	☐	☐	Other: _____
☐	☐	Other: _____	☐	☐	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 Perfomance & 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:

Healthway Compounding Pharmacy
2544 McLeod Dr., N., Ste. 2
Saginaw, MI 48604
Fax: 989-791-4603