

# PRO COMPOUNDING PHARMACY <sup>Rx</sup>

527 N. State of Franklin Rd, Johnson City, TN 37604

Phone: 423-975-0597 Fax: 423-975-6304

www.ProCompounding.com

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Height \_\_\_\_\_ Weight: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Have you discussed hormone therapy with him / her? **YES NO**

**Medical & Social History:** Please check the following that apply to you.

- |   |   |
|---|---|
| <input type="checkbox"/> High Blood Pressure          | <input type="checkbox"/> Alcohol Use          |
| <input type="checkbox"/> High Cholesterol             | <input type="checkbox"/> Erectile Dysfunction |
| <input type="checkbox"/> Cardiovascular Disease       | <input type="checkbox"/> Insomnia             |
| <input type="checkbox"/> Diabetes Mellitus            | <input type="checkbox"/> Malnutrition         |
| <input type="checkbox"/> Osteoporosis                 | <input type="checkbox"/> Depression           |
| <input type="checkbox"/> Benign Prostatic Hyperplasia | <input type="checkbox"/> Cancer: _____        |
| <input type="checkbox"/> Tobacco Use                  | <input type="checkbox"/> Other: _____         |
| <input type="checkbox"/> Asthma / COPD                |   |

**Medication History:** List all prescription and non-prescription medications that you are taking. (Including vitamins, herbals, and supplements.)

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**Drug Allergies:** \_\_\_\_\_

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**Circle Yes Or No to the following questions. If yes, indicate if Mild, Moderate, or Severe.**

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|--|---------------|
| 1. Do you feel more fatigued or tired than usual?<br>If yes, circle: <b>Mild Moderate Severe</b>   | <b>Yes No</b> |
| 2. Have you noticed a decrease in your muscle mass?<br>If yes, circle: <b>Mild Moderate Severe</b> | <b>Yes No</b> |
| 3. Have you experienced a loss in muscle strength?<br>If yes, circle: <b>Mild Moderate Severe</b>  | <b>Yes No</b> |

4. Have you experienced an increase in joint and/or muscle pain? **Yes No**  
 If yes, circle: **Mild Moderate Severe**
5. Have you noticed an increase in your waist size? **Yes No**  
 If yes, circle: **Mild Moderate Severe**
6. Do you have trouble losing weight? **Yes No**  
 If yes, circle: **Mild Moderate Severe**
7. Have you experienced a loss in height? **Yes No**  
 If yes, circle: **Mild Moderate Severe**
8. Do you have a decrease in sex drive? **Yes No**  
 If yes, circle: **Mild Moderate Severe**
9. Have you experienced difficulty in establishing and/or maintaining full erections? **Yes No**  
 If yes, circle: **Mild Moderate Severe**
10. Do you have a decrease in spontaneous early morning erections? **Yes No**  
 If yes, circle: **Mild Moderate Severe**
11. Have you experienced changes in your usually sleep pattern? **Yes No**  
 If yes, circle: **Mild Moderate Severe**
12. Do you feel a decrease in your mental sharpness? **Yes No**  
 If yes, circle: **Mild Moderate Severe**
13. Have you had trouble concentrating? **Yes No**  
 If yes, circle: **Mild Moderate Severe**
14. Do you experience less enjoyment in personal interests and hobbies? **Yes No**  
 If yes, circle: **Mild Moderate Severe**
15. I am \_\_\_\_\_ years old. I feel \_\_\_\_\_ years old.
16. How did you hear about our Men's Health Hormone Replacement Program?  
**Radio Billboard Friend Newspaper Doctor Other \_\_\_\_\_**
17. What are your major complaints or symptoms that led you to pursue hormone replacement therapy? \_\_\_\_\_  
 \_\_\_\_\_  
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 \_\_\_\_\_  
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**Upon completion of this form, please call (423) 975-0597 to schedule a consult with a ProCompound-  
 ing Pharmacy Hormone Therapy Specialist. You may fax the form to (423) 975-6304, ATTN: Keri OR  
 bring the form with you to your appointment.**