PRO COMPOUNDING PHARMACY Rx

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.

___ High Blood Pressure
___ High Cholesterol
___ Cardiovascular Disease
___ Diabetes Mellitus
___ Osteoporosis
___ Benign Prostatic Hyperplasia
___ Tobacco Use
___ Asthma / COPD
___ Alcohol Use
___ Erectile Dysfunction
___ Insomnia
___ Malnutrition
___ Depression
___ Cancer: _____
___ Other: _____

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

_____

_____

_____

_____

_____

Drug Allergies: _____

_____

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

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

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? _____

_____

_____

_____

_____

_____

_____

_____

Upon completion of this form, please call (423) 975-0597 to schedule a consult with a ProCompounding Pharmacy Hormone Therapy Specialist. You may fax the form to (423) 975-6304, ATTN: Keri OR bring the form with you to your appointment.