PRO COMPOUNDING PHARMACY Rx

Topical Pain • Ear, Nose & Throat • Podiatry • Veterinary • Wound Care
Men's Health • Women's Health • Sexual Health • Hormone Replacement

527 N. State of Franklin Road • Johnson City, TN 37604 • Phone: (423) 975-0597 • Fax: (423) 975-6304
77 Airport Road • Arden, NC 28704 • Phone: (828) 676-1677 • Fax: (828) 214-3999
WWW.PROCOMPOUNDING.COM

Men's Health Profile/Questionnaire

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 Prostate Hyperplasia
___Tobacco Use
___Asthma/COPD
___Alcohol Use
___Erectile Dysfunction
___Insomnia
___Malnutrition
___Depression
___Cancer: _____
___Other: _____

Medication History: List all prescription and non-prescription medications you are currently 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 and/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 pains? **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 your sex drive? **Yes** **No**

   If yes, circle: **Mild** **Moderate** **Severe**

9. Have 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 usual 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/Bio-Identical 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) 957-0597, to schedule a consult with a ProCompounding Pharmacy Hormone Therapy Specialist.

You may fax the form to (423) 975-6304

OR

bring the form with you to your appointment.