Wasatch Pharmacy Care
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801-479-0331
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Male Hormone Screening

Name________________________________ Today's Date__________
Address____
Phone____________________ E-mail address______________________
Date of Birth______________ Height______ Weight_____ Race__________
Marital Status________________ Profession_________________________

Doctor's Name____________________________________
Doctor's Address and phone_______________________________________

Medication History:

Prescription Medications Taken: Conditions Taken For

______________________________ ____________________
______________________________ ____________________
______________________________ ____________________
______________________________ ____________________
______________________________ ____________________

What non-prescription products do you use? (vitamins, minerals, herbals, pain relievers):
____
____

Have you ever taken any type of hormone replacement before?__________________
If yes, describe____
Any drug allergies you may have:_______________________________________

Medical History:

Have you been diagnosed with osteoporosis?______________________________
Does anyone in your family have a history of osteoporosis?____________________
Have you had a fracture?______If yes, what type and what age?_______________
Have you had a bone density scan?________If yes, when?____________________
Results' if known____
Have you been diagnosed with high blood pressure?________Angina?________
Heart Disease?___________
Does anyone in your family have a history of : (please list relation to you and age)
High Blood Pressure?______________________________________
Stroke?____
Heart Disease?____
Do you currently smoke?________Are you an ex-smoker?_____________________
When did you last have your cholesterol checked?_____________________________
results, if known: HDL_______LDL_______Total________Triglycerides______
Have you been told that you have prostate cancer?_____________________________
Date of last blood test or rectal exam to check prostate:________Results:______________
Do you have a family history of prostate cancer?_________________________________

Have you ever been told you have an enlarged prostate?__________________

Do you have any of the following urinary symptoms: If yes, how often?:
Incomplete bladder emptying, frequency, intermittency, urgency, weak stream, straining or nocturia____
____
____

Rate the following as they apply to you.
Use the numbers 1 - 4, with 1 being Rare or Mild, and 4 being Frequent or Severe.

		Rare	Mild	Frequent	Severe
1.	Fatigue, tiredness or loss of energy	1	2	3	4
2.	Decrease in physical stamina	1	2	3	4
3.	Feelings of depression - a sense that work, marriage or recreational activities have lost significance	1	2	3	4
4.	Decreased libido - less desire for sex	1	2	3	4
5.	Erection or potency problems	1	2	3	4
6.	Loss of early morning erection	1	2	3	4
7.	Dry skin on face or hands	1	2	3	4
8.	Increase in waist size - weight gain, especially around mid-section	1	2	3	4
9.	Increased fat distribution in chest area or hips	1	2	3	4
10.	Feeling burned out, loss of motivation	1	2	3	4
11.	Increase in aches, joint and muscle pains	1	2	3	4
12.	Frequent use of alcohol - now or in the past	1	2	3	4
13.	Increased irritability, anger or bad temper	1	2	3	4
14.	Decrease in muscle mass	1	2	3	4

15. The age you are: _______ The age you feel: ________

Pharmacy Record Release Authorization

I, undersigned patient, authorize my pharmacist to release my personal medication and /or other medical information to the following persons or organizations upon request or as deemed necessary:

	Name	Address	Telephone
1)			
2)			
3)			

I understand that employees of ______________________________ Pharmacy will protect my privacy and this information will be released to other health care profess-ionals only when it is necessary in order to provide health care services to me. This authority shall continue until revoked by me in writing.

Patient Name: ______________________________

Address: ______________________________

City,State,Zip: ______________________________

Phone: ______________________________

Signature: ______________________________

Date: ______________________________

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