CONFIDENTIAL HORMONE EVALUATION - MALE

Today's Date: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____City _____ State: _____Zip:_____

Phone: _____ Cell:_____ E-Mail Address: _____
(Please indicate with an * which way you would like us to contact you)

Doctor's Name: _____ Address: _____ Phone: _____
_____
_____
_____
_____

Allergies: Please check all that apply

___ penicillin ___ morphine ___ dye allergies ___ pet allergies
___ codeine ___ aspirin ___ nitrate allergy ___seasonal allergies
___ sulfa drug ___ food allergies ___ no known allergies

Other: _____

Please describe the allergic reaction: _____
_____

Medical Conditions/Diseases: Please check all that apply to you.

___ heart disease (example: congestive heart failure) ___ blood clotting problems
___ high cholesterol ___ high triglycerides ___ diabetes
___ high blood pressure ___ arthritis ___ cancer (type:_____)
___ depression ___ headaches/migraines ___ epilepsy
___ ulcers ___ chronic pain ___ GERD
___ hypothyroidism ___ hyperthyroidism ___ asthma
___ emphysema ___ COPD ___ glaucoma
___ psoriasis ___ Benign Prostatic Hypertrophy (BPH)
___ irritable bowel syndrome (IBS/IBD) ___ fibromyalgia
___ Other: _____

PATIENT NAME: _____

Magnolia Pharmacy
CUSTOM CREATIONS
EST. 2002
HOMETOWN VALUES

Current Medications: Please list all medications you are currently taking. Include prescription medications, over the counter medications, and supplements/herbs.

Name of Medication	Dose	Times per day	Date Started

Height:_____ Weight:_____
BMI (Pharmacist will calculate)_____ (BMI = weight in kg/height in meters^2)
BMI results adults over 35:

19-26.9	Recommended	30-39.9	Obese
27-29.9	Overweight	40+	Morbidly Obese

Waist Circumference: _____ Waist/Hip Ratio:_____
Hip Circumference: _____

What is your desired weight? _____

How were you born: Natural Delivery_____ C-Section: _____

Do you have a family history of any of the following?

Uterine Cancer_____ Family member(s) _____
Ovarian Cancer_____ Family member(s) _____
Fibrocystic breast_____ Family member(s) _____
Breast Cancer_____ Family member(s) _____
Heart Disease_____ Family member(s) _____
Osteoporosis_____ Family member(s) _____
Colon Cancer _____Family member(s) _____
Diabetes _____ Family member(s) _____

Have you had any of the following tests performed? Check those that apply and note date of last test.

PSA _____ No _____ Yes Date: _____

Colonoscopy _____ No _____ Yes Date: _____

PATIENT NAME: _____

Did you receive a Covid vaccine? NO _____ YES _____ If yes, # of doses: _____
Do you smoke? NO _____ YES _____ – how much and for how long_____
How many caffeinated beverages do you drink per day? _____
Portion size_____
How much water do you drink per day? _____ Portion size_____
How many alcoholic beverages do you consume in an average week?
_____
Do you use THC or CBD containing products? NO _____ YES _____
If yes, what type of products do you use _____
How many bowel movements do you have per day? _____
If you have food cravings, what type of cravings do you have (select all that apply): ___ salty foods ___ sweet and sugary foods ___ chocolate ____
___ carbohydates (breads, pasta, etc) ____ fatty foods

How many meals a day do you eat? _____
Please describe your:
Typical breakfast: _____
_____
Typical lunch: _____
_____
Typical dinner: _____
_____

Do you have trouble waking up in the mornings? _____ No _____ Yes
Do you take naps during the day? _____ No _____ Yes
Do you have trouble falling asleep at night? _____ No _____ Yes
Do you have trouble staying asleep? _____ No _____ Yes
Comments about sleep patterns: _____
_____

Do you work outside the home? _____ No _____ Yes
How many hours per week? _____
What do you do for a living? _____
Do you enjoy your job? _____
Do you find your job stressful? _____
Do you find your job satisfying? _____
Do you take care of small children, elderly, or disabled adults? _____ No ____ Yes
If Yes, explain:_____
_____

PATIENT NAME: _____

Do you have a hobby? _____ No _____ Yes
What activity relaxes you? _____
How often are you able to do this activity? _____
Is there a place in your home that you can go to relax and be alone?
____No ___Yes
Do you belong to a social or activity group outside of your family?
____ No ____ Yes
Do you have a current exercise routine?
_____No_____ Yes
If Yes, what kind of exercise and how often per week: _____
_____
Comments:_____

PATIENT NAME: _____

Please rate the following symptoms in severity from 0 to 3, 0 being absent and 3 being severe.

Fatigue	_____
Decrease in Physical Stamina	_____
Erection or Potency Problems	_____
Loss of early morning erection	_____
Anxiety	_____
Depression	_____
Decreased libido	_____
Foggy Thinking	_____
Loss of Memory	_____
Irritability	_____
Trouble Sleeping	_____
Sugar Craving	_____
Morning Fatigue	_____
Evening Fatigue	_____
Arthritis	_____
Bone Loss	_____
Dry Skin	_____
Dry/Brittle Hair	_____
Dry/Brittle Nails	_____
Hair Loss	_____
Constipation	_____
Weight Gain - Hips	_____
Weight Gain – Waist	_____

Symptom Numerical Total_____

How did you arrive at the decision to consider Bio-Identical Hormone Replacement Therapy?

Doctor _____ Self _____ Friend/Family Member _____ Other _____

What are your goals with taking hormone replacment?

_____
_____
_____
_____
_____
_____
_____
_____

PATIENT NAME: _____

Please list the health goals you hope to achieve by completing the appointment:

PATIENT NAME: _____

LIFE STRESS TEST

In a now-famous American study from 1967, Dr. Thomas H. Holmes and Dr. Richard H. Rahe created a do-it-yourself stress test. They examined the stress - measured the Life Changes (LCU) . that induced by experiences ranging from death of a spouse to getting a traffic ticket. By adding the LCU values of the <u>past year</u>, you can predict the likelihood of stress related illness or accident.

CHANCE OF ILLNESS OR ACCIDENT WITHIN 2 YEARS.

Total LCU below 150 . 35%
Total LCU between . 150 to 300 . 51%
Total LCU over 300 . 80%

_____Death of Spouse - 100
_____ Divorce . 73
_____ Marital Separation . 65
_____ Jail Term . 63
_____ Death of close family member . 63
_____ Personal injury or illness . 53
_____ Marriage . 50
_____ Fired from work . 47
_____ Marital reconciliation . 45
_____ Retirement . 45
_____ Change in family members health . 44
_____ Pregnancy . 40
_____ Sex difficulties . 39
_____ Addition to family . 39
_____ Business readjustment . 39
_____ Change in financial status . 38
_____ Death of close friend . 37
_____ Change to different line of work . 36
_____ Change in number of marital arguments . 35
_____ Mortgage or loan over $10.000 . 31
_____ Foreclosure of mortgage or loan . 30

_____ Change in work responsibilities . 29
_____ Trouble with in-laws . 29
_____ Outstanding personal achievement . 28
_____ Spouse begins or stops work . 26
_____ Starting or finishing school . 26
_____ Change in living conditions . 25
_____ Revision of personal habits . 24
_____ Trouble with boss . 23
_____ Change in work hours or conditions . 20
_____ Change in residence . 20
_____ Change in schools . 20
_____ Change in recreational habits . 19
_____ Change in social activities . 18
_____ Mortgage or loan under $10,000 . 17
_____ Change in sleeping habits . 16
_____ Change in number of family gatherings . 15
_____ Change in eating habits . 15
_____ Vacation . 13
_____ Christmas season . 12
_____ Minor violations of the law . 11

_____ **YOUR TOTAL**

This scale shows the kind of life pressure that you are facing. Depending on your coping skills or the lack thereof, this scale may predict the likelihood that you will fall victim to a stress related illness. This illness could be frequent tension headaches, acid indigestion, loss of sleep, to very serious illness like ulcers, cancer and migraines.

Daily practice of relaxation skills is very important for your wellness.
Take care of it now before serious illness erupts or an affliction becomes worse.

PATIENT NAME: _____