OKULEY'S PHARMACY

Medical Equipment • Specialty Medications

MALE

CONSULTANT PHARMACIST AGREEMENT

For

New Patients Starting Natural Bio-Identical Hormone Replacement Therapy

Okuley's offers an ongoing consultation service for women and men who are receiving bio-identical natural hormone replacement therapy. A consulting fee of $125.00 for a 60 minute consult will be charged to you when you start natural bio-identical hormone replacement therapy. This fee covers services you receive with our clinical pharmacists, including: initial work-up and consultation with you and your physician. You will be asked to make follow-up visits 1, 3, 6, and 12 months after starting your therapy. Each follow-up visit carries a fee of $50.00 and lasts up to 30 minutes. Follow-up visits are needed to adjust therapies and ensure you are well balanced.

What can I expect?

***We will work closely with your doctor to find the right therapy to meet your needs. It is important for you, as the patient, to communicate regularly with your physician about your goals. If your doctor needs more information about Bio-identical Hormone Replacement Therapy, we would be happy to provide it to him/her. The success of your therapy is greatly dependent upon a positive physician/pharmacist relationship.**

***Unlike the commercial hormone replacement therapies with only a few strengths, Bio-identical hormones can be formulated in any dosage, and in a variety of forms to meet your personal needs.**

***There will be an adjustment period of approximately three months, though the time frame may vary slightly from one person to the next. During this initial period, we will be in contact with you to discuss your symptoms and answer any questions you may have regarding your therapy. Successful hormone replacement therapy requires patience and consistent communication with your health care professionals.**

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ADRENAL QUESTIONAIRE

If you answer yes to 3 or more of these questions, you may have some degree of adrenal burnout:

Are you tired for “no reason”?

Do you have trouble getting up in the morning?

Do you need coffee or colas to keep you going?

Do you feel run down and stressed?

Do you crave salty or sweet snacks?

Are you struggling to keep up with life’s daily demands?

Can you not bounce back from stress or illness?

Are you not having fun anymore?

Is your sex drive decreased?

Do you have difficulty falling/staying asleep or do you have trouble shutting your mind off at night?

Do you have vivid nightmares or dreams?

Do you have low blood pressure (lower than 110 on the top and lower than 70 on the bottom)?

Do you feel as if you could take a nap an hour or so after lunch?

Do you eat at least one processed or sweetened food at each meal or frequently skip meals?

Are your pupils normally dilated even during the day?

Do you seem to get sick or suffer from allergies more frequently than you used to?

Do you feel pressured or rushed often during the day?

Do you experience lightheadedness, mood swings or headaches if you go more than 4-6 hours between meals?

MEMORY QUESTIONAIRE

Over the last year, I have experienced:

_____ Becoming forgetful

_____ Lapses in memory

_____ Becoming less attentive

_____ Less interest in normal activities

_____ Feeling less sharp

_____ Difficulty remembering people's names

_____ Difficulty making decisions

_____ Problems finding the right words to communicate

_____ Difficulty solving routine problems

_____ Difficulty learning new things

_____ Problems writing, reading, or organizing thoughts

_____ Difficulty following instructions

Amino Acid Deficiency Symptoms

Instructions: Mark the box or boxes that identify your corresponding symptoms.

L-glutamine

- ☐ Cravings for sugar, starch, or alcohol
- ☐ Reduced mental stability

L-tyrosine, L-phenylalanine

- ☐ Depression
- ☐ Lack of energy
- ☐ Lack of drive
- ☐ Lack of focus, concentration

GABA

- ☐ Stiff and tense muscles
- ☐ Stressed
- ☐ Feeling "burned out"
- ☐ Unable to relax

DL-phenylalanine, D-phenylalanine

- ☐ Very sensitive to emotional or physical pain
- ☐ Cry easily
- ☐ Crave comfort, reward, or numbing treats
- ☐ "Love" certain foods or drugs

L-tryptophan, 5-HTP (serotonin), Melatonin (sleep)

- ☐ Depression, Negativity
- ☐ Worry, anxiety
- ☐ Low self-esteem
- ☐ Obsessive thoughts/behaviors
- ☐ The "winter blues"
- ☐ PMS
- ☐ Irritability, rage
- ☐ Heat intolerance
- ☐ Panic, phobias
- ☐ Afternoon or evening cravings
- ☐ Fibromyalgia, TMJ
- ☐ Sleep disturbances – hard time getting to sleep, or staying asleep
- ☐ Suicidal thoughts

Do you crave any of the following to compensate for the above symptoms? (Circle)

- ☐ Sweets, starches, alcohol, chocolate, caffeine, tobacco, marijuana, cocaine, heroin

HEALTH APPRAISAL QUESTIONNAIRE

Name _____ **Date** _____

DIRECTIONS

This questionnaire asks you to assess how you have been feeling **during the last four months**. This information will help you keep track of how your physical, mental and emotional states respond to changes you make in your eating habits, priorities, supplement program, social and family life, level of physical activity and time spent on personal growth. All information is held in strict confidence. Take all the time you need to complete this questionnaire.

For each question, circle the number that best describes your symptoms:

0 = No or Rarely—You have never experienced the symptom or the symptom is familiar to you but you perceive it as insignificant (monthly or less)

1 = Occasionally—Symptom comes and goes and is linked in your mind to stress, diet, fatigue or some identifiable trigger

4 = Often—Symptom occurs 2-3 times per week and/or with a frequency that bothers you enough that you would like to do something about it

8 = Frequently—Symptom occurs 4 or more times per week and/or you are aware of the symptom every day, or it occurs with regularity on a monthly or cyclical basis

Some questions require a YES or NO response: 0 = NO 8 = YES

PART I

	No/Rarely	Occasionally	Often	Frequently
SECTION A				
1. Indigestion, food repeats on you after you eat	0	1	4	8
2. Excessive burping, belching and/or bloating following meals	0	1	4	8
3. Stomach spasms and cramping during or after eating	0	1	4	8
4. A sensation that food just sits in your stomach creating uncomfortable fullness, pressure and bloating during or after a meal	0	1	4	8
5. Bad taste in your mouth	0	1	4	8
6. Small amounts of food fill you up immediately	0	1	4	8
7. Skip meals or eat erratically because you have no appetite	0	1	4	8
Total points				
SECTION B				
1. Strong emotions, or the thought or smell of food aggravates your stomach or makes it hurt	0	1	4	8
2. Feel hungry an hour or two after eating a good-sized meal	0	1	4	8
3. Stomach pain, burning and/or aching over a period of 1-4 hours after eating	0	1	4	8
4. Stomach pain, burning and/or aching relieved by eating food; drinking carbonated beverages, cream or milk; or taking antacids	0	1	4	8
5. Burning sensation in the lower part of your chest, especially when lying down or bending forward	0	1	4	8
6. Digestive problems that subside with rest and relaxation	(0)No			(8)Yes
7. Eating spicy and fatty (fried) foods, chocolate, coffee, alcohol, citrus or hot peppers causes your stomach to burn or ache	0	1	4	8
8. Feel a sense of nausea when you eat	0	1	4	8
9. Difficulty or pain when swallowing food or beverage	0	1	4	8
Total points				
SECTION C				
1. When massaging under your rib cage *on your left side*, there is pain, tenderness or soreness	0	1	4	8
2. Indigestion, fullness or tension in your abdomen is delayed, occurring 2-4 hours after eating a meal	0	1	4	8
3. Lower abdominal discomfort is relieved with the passage of gas or with a bowel movement	0	1	4	8
4. Specific foods/beverages aggravate indigestion	0	1	4	8
5. The consistency or form of your stool changes (e.g., from narrow to loose) within the course of a day	0	1	4	8

	No/Rarely	Occasionally	Often	Frequently
SECTION C *(cont.)*				
6. Stool odor is embarrassing	0	1	4	8
7. Undigested food in your stool	0	1	4	8
8. Three or more large bowel movements daily	0	1	4	8
9. Diarrhea (frequent loose, watery stool)	0	1	4	8
10. Bowel movement shortly after eating (within 1 hour)	0	1	4	8
Total points				
SECTION D				
1. Discomfort, pain or cramps in your colon (lower abdominal area)	0	1	4	8
2. Emotional stress and/or eating raw fruits and vegetables causes abdominal bloating, pain, cramps or gas	0	1	4	8
3. Generally constipated (or straining during bowel movements)	0	1	4	8
4. Stool is small, hard and dry	0	1	4	8
5. Pass mucus in your stool	0	1	4	8
6. Alternate between constipation and diarrhea	0	1	4	8
7. Rectal pain, itching or cramping	0	1	4	8
8. No urge to have a bowel movement	(0)No			(8)Yes
9. An almost continual need to have a bowel movement	(0)No			(8)Yes
Total points				

PART II

1. When massaging under your rib cage *on your right side*, there is pain, tenderness or soreness	0	1	4	8
2. Abdominal pain worsens with deep breathing	0	1	4	8
3. Pain at night that may move to your back or right shoulder	0	1	4	8
4. Bitter fluid repeats after eating	0	1	4	8
5. Feel abdominal discomfort or nausea when eating rich, fatty or fried foods	0	1	4	8
6. Throbbing temples and/or dull pain in forehead associated with overeating	0	1	4	8
7. Unexplained itchy skin that's worse at night	0	1	4	8
8. Stool color alternates from clay colored to normal brown	0	1	4	8
9. General feeling of poor health	0	1	4	8

PART II

	No/Rarely	Occasionally	Often	Frequently
10. Aching muscles not due to exercise	0	1	4	8
11. Retain fluid and feel swollen around the abdominal area	0	1	4	8
12. Reddened skin, especially palms	0	1	4	8
13. Very strong body odor.	0	1	4	8
14. Are you embarrassed by your breath?	0	1	4	8
15. Bruise easily	(0)No			(8)Yes
16. Yellowish cast to eyes	(0)No			(8)Yes

Total points ____

PART III

SECTION A

1. Feel cold or chilled—hands, feet or all over—for no apparent reason	0	1	4	8
2. Your upper eyelids look swollen	0	1	4	8
3. Muscles are weak, cramp and/or tremble	0	1	4	8
4. Are you forgetful?	0	1	4	8
5. Do you feel like your heart beats slowly?	0	1	4	8
6. Reaction time seems slowed down	0	1	4	8
7. In general, are you disinterested in sex because your desire is low?	0	1	4	8
8. Feel slow-moving, sluggish	0	1	4	8
9. Constipation	0	1	4	8
10. Dryness, discoloration of skin and/or hair	(0)No			(8)Yes
11. Have you noticed recently that your voice is deepening?	(0)No			(8)Yes
12. Thick, brittle nails	(0)No			(8)Yes
13. Weight gain for no apparent reason	(0)No			(8)Yes
14. Outer third of your eyebrow is thinning or disappearing	(0)No			(8)Yes
15. Swelling of the neck	(0)No			(8)Yes

Total points ____

SECTION B

1. Lingering mild fatigue after exertion or stress	0	1	4	8
2. Do you find that you get tired and exhaust easily?	0	1	4	8
3. Craving for salty foods	0	1	4	8
4. Sensitive to minor changes in weather and surroundings	0	1	4	8
5. Dizzy when rising or standing up from a kneeling position	0	1	4	8
6. Dark bluish or black circles under your eyes	0	1	4	8
7. Have bouts of nausea with or without vomiting	0	1	4	8
8. Catch colds or infections easily	(0)No			(8)Yes
9. Wounds heal slowly	(0)No			(8)Yes
10. Your body or parts of your body feel tender, sore, sensitive to the touch, hot and/or painful	0	1	4	8
11. Feel puffy and swollen all over your body	0	1	4	8
12. Skin is gradually tanning without exposure to sun or the ingestion of high levels of carotene-rich foods (e.g., daily carrot juice intake) or supplements	(0)No			(8)Yes

Total points ____

PART IV

	No/Rarely	Occasionally	Often	Frequently

SECTION A

When you miss meals or go without food for extended periods of time, do you experience any of the following symptoms?

1. A sense of weakness	0	1	4	8
2. A sudden sense of anxiety when you get hungry	0	1	4	8
3. Tingling sensation in your hands	0	1	4	8
4. A sensation of your heart beating too quickly or forcefully	0	1	4	8
5. Shaky, jittery, hands trembling	0	1	4	8
6. Sudden profuse sweating and/or your skin feels clammy	0	1	4	8
7. Nightmares possibly associated with going to bed on an empty stomach	0	1	4	8
8. Wake up at night feeling restless	0	1	4	8
9. Agitation, easily upset, nervous	0	1	4	8
10. Poor memory, forgetful	0	1	4	8
11. Confused or disoriented	0	1	4	8
12. Dizzy, faint	0	1	4	8
13. Cold or numb	0	1	4	8
14. Mild headaches or head pounding	0	1	4	8
15. Blurred vision or double vision	0	1	4	8
16. Feel clumsy and uncoordinated	0	1	4	8

Total points ____

SECTION B

1. Frequent urination during the day and night	0	1	4	8
2. Unusual thirst—feeling like you can't drink enough water	0	1	4	8
3. Unusual hunger—eating all the time	0	1	4	8
4. Vision blurs	0	1	4	8
5. Feel itchy all over	0	1	4	8
6. Tingling or numbness in your feet	0	1	4	8
7. Sense of drowsiness, lethargy during the day not associated with missing meals or not sleeping	0	1	4	8
8. Eating starchy foods, even if they are healthy and unprocessed (like rice, corn, beans, whole wheat or oats), causes you to gain weight or prevents you from losing weight	(0)No			(8)Yes
9. Sores heal slowly	(0)No			(8)Yes
10. Loss of hair on your legs	(0)No			(8)Yes

Total points ____

PART V

SECTION A

1. Feel jittery	0	1	4	8
2. First effort of the day causes pain, pressure, tightness or heaviness around the chest	0	1	4	8
3. Exhaustion with minor exertion	0	1	4	8
4. Heavy sweating (no exertion, no hot flashes)	0	1	4	8
5. Difficulty catching breath, especially during exercise	0	1	4	8
6. Heart pounding, sensation of heart beating too quickly, too slowly or irregularly	0	1	4	8
7. Swelling in feet, ankles and/or legs comes and goes for no apparent reason	0	1	4	8

Total points ____

PART V (cont.)

	No/Rarely	Occasionally	Often	Frequently
SECTION B				
1. Muscle pain at rest	0	1	4	8
2. Cramp-like pains in your ankles, calves or legs	0	1	4	8
3. Numbness, tingling and prickling sensation in hands and feet	0	1	4	8
4. Cold feet and/or toes appear blue	0	1	4	8
5. Brief moments of hearing loss	0	1	4	8
6. Nausea comes and goes quickly (unrelated to eating)	0	1	4	8
7. Feel worse standing: legs get heavy and fatigued	0	1	4	8
8. Leg discomfort or fatigue relieved by elevating legs	0	1	4	8
9. Fingers and toes get numb in cold weather even when protected	0	1	4	8
10. Notice changes in your ability to feel pain or differentiate between sensations of hot or cold	(0)No			(8)Yes
11. Body hair (on arms, hands, fingers, legs and toes) is thinning or has disappeared	(0)No			(8)Yes
12. Do you notice a decline in your ability to make decisions, concentrate, focus attention or follow directions?	(0)No			(8)Yes
Total points				

PART VI

SECTION A

1. Family, friends, work, hobbies or activities you hold dear are no longer of interest	0	1	4	8
2. Do you cry?	0	1	4	8
3. Does life look entirely hopeless?	0	1	4	8
4. Would you describe yourself as feeling miserable and sad, unhappy or blue?	0	1	4	8
5. Do you find it hard to make the best of difficult situations?	0	1	4	8
6. Sleep problems—too much or too little sleep	0	1	4	8
7. Changes in your appetite and weight	(0)No			(8)Yes
8. Lately you've noticed an inability to think clearly or concentrate	(0)No			(8)Yes
9. Difficulty making decisions and/or clarifying and achieving your goals	(0)No			(8)Yes
Total points				

SECTION B

1. Does worrying get you down?	0	1	4	8
2. Does every little thing get on your nerves and wear you out?	0	1	4	8
3. Would you consider yourself a nervous person?	0	1	4	8
4. Do you feel easily agitated?	0	1	4	8
5. Do you shake and tremble?	0	1	4	8
6. Are you keyed up and jittery?	0	1	4	8
7. Do you tremble or feel weak when someone shouts at you?	0	1	4	8
8. Do you become scared at sudden movements or noises at night?	0	1	4	8
9. Do you find yourself sighing a lot?	0	1	4	8
10. Are you awakened out of your sleep by frightening dreams?	0	1	4	8
11. Do frightening thoughts keep coming back in your mind?	0	1	4	8

	No/Rarely	Occasionally	Often	Frequently
SECTION B *(cont.)*				
12. Do you become suddenly scared for no reason?	0	1	4	8
13. Do you break out in a cold sweat?	0	1	4	8
14. "Butterflies in your stomach," nausea and/or diarrhea	0	1	4	8
Total points				

SECTION C

1. Do you feel pent up and ready to explode?	0	1	4	8
2. Are you prone to noisy and emotional outbursts?	0	1	4	8
3. Do you do things on impulse?	0	1	4	8
4. Are you easily upset or irritated?	0	1	4	8
5. Do you go to pieces if you don't control yourself?	0	1	4	8
6. Do little annoyances get on your nerves and make you angry?	0	1	4	8
7. Does it make you angry to have anyone tell you what to do?	0	1	4	8
8. Do you flare up in anger if you can't have what you want right away?	0	1	4	8
Total points				

PART VII

1. Eyes water or tear	0	1	4	8
2. Mucus discharge from the eyes	0	1	4	8
3. Ears ache, itch, feel congested or sore	0	1	4	8
4. Discharge from ears	0	1	4	8
5. Is your nose continually congested?	0	1	4	8
6. Are you prone to loud snoring?	(0)No			(8)Yes
7. Does your nose run?	0	1	4	8
8. Nosebleeds	(0)No			(8)Yes
9. Hoarse voice	0	1	4	8
10. Do you have to clear your throat?	0	1	4	8
11. Do you feel a choking lump in your throat?	0	1	4	8
12. Do you suffer from severe colds?	(0)No			(8)Yes
13. Do frequent colds keep you miserable all winter?	(0)No			(8)Yes
14. Flu symptoms last longer than 5 days	(0)No			(8)Yes
15. Do infections settle in your lungs?	(0)No			(8)Yes
16. Chest discomfort or pain	0	1	4	8
17. Do you experience sudden breathing difficulties?	0	1	4	8
18. Do you struggle with shortness of breath?	0	1	4	8
19. Difficulty exhaling (breathing out)	0	1	4	8
20. Breathlessness followed by coughing during exertion, no matter how slight	0	1	4	8
21. Inability to breathe comfortably while lying down	0	1	4	8
22. Do you cough up lots of phlegm?	0	1	4	8
23. Can you hear noisy rattling sounds when breathing in and out?	0	1	4	8
24. Are you troubled with coughing?	0	1	4	8
25. Do you wheeze?	0	1	4	8
26. Do you have severe soaking sweats at night?	0	1	4	8
27. Do your lips and/or nails have a bluish hue?	0	1	4	8
28. Are you sleepy during the day?	0	1	4	8

PART VII (cont.)

	No/Rarely	Occasionally	Often	Frequently
29. Do you have difficulty concentrating?	0	1	4	8
30. Eyes, ears, nose, throat and lung symptoms seem associated with specific foods like dairy or wheat products	(0)No			(8)Yes
31. Eyes, ears, nose, throat and lung symptoms are associated with seasonal changes	(0)No			(8)Yes

Total points ____

PART VIII

1. Involuntary loss of urine when you cough, lift something or strain during an activity	0	1	4	8
2. Mild lower back ache or pain	0	1	4	8
3. Abdominal achiness or pain	0	1	4	8
4. Pain or burning when urinating	0	1	4	8
5. Rarely feel the urge to urinate	0	1	4	8
6. Feel the need to urinate less than every two hours during the day or night	0	1	4	8
7. Strong smelling urine	0	1	4	8
8. Back or leg pains are associated with dripping after urination	0	1	4	8
9. Sore or painful genitals	0	1	4	8
10. Urine is a rose color	0	1	4	8
11. Sudden urge to void causes involuntary loss of urine	0	1	4	8
12. Generalized sense of water retention throughout your body	0	1	4	8

Total points ____

PART IX

SECTION A

1. Bones throughout your entire body ache, feel tender or sore	0	1	4	8
2. Localized bone pain	0	1	4	8
3. Hands, feet or throat get tight, spasm or feel numb	0	1	4	8
4. Difficulty sitting straight	0	1	4	8
5. Upper back pain	0	1	4	8
6. Lower back pain	0	1	4	8
7. Pain when sitting down or walking	0	1	4	8
8. Find yourself limping or favoring one leg	0	1	4	8
9. Shins hurt during or after exercise	0	1	4	8

Total points ____

SECTION B

1. Are you stiff in the morning when you wake up?	0	1	4	8
2. Difficulty bending down and picking up clothing or anything from the floor	0	1	4	8
3. Joint swelling, pain or stiffness involving one or more areas (fingers, hands, wrists, elbows, shoulders, toes, arches, feet, ankles, knees or ankles)	0	1	4	8
4. Joints hurt when moving or when carrying weight	0	1	4	8
5. A routine exercise program, like daily walking, causes your knees to swell or hurt	0	1	4	8
6. Difficulty opening jars that were previously easy to open	0	1	4	8
7. Discomfort, numbness, prickling or tingling sensation, or pain in neck, shoulder or arm	0	1	4	8

	No/Rarely	Occasionally	Often	Frequently
SECTION B *(cont.)*				
8. Intermittent pain or ache on one side of head spreading to cheek, temple, lower jaw, ear, neck and shoulder	0	1	4	8
9. Difficulty chewing food or opening mouth	0	1	4	8
10. Difficulty standing up from a sitting position	0	1	4	8
11. Shooting, aching, tingling pain down the back of leg	0	1	4	8
12. Is it difficult to reach up and get a 5-pound object like a bag of flour from just above your head?	(0)No			(8)Yes
13. Injure, strain or sprain easily	(0)No			(8)Yes

Total points ____

SECTION C

1. Muscles stiff, sore, tense and/or achy	0	1	4	8
2. Burning, throbbing, shooting or stabbing muscle pain	0	1	4	8
3. Muscle cramps or spasms (involuntary or after exertion/exercise)	0	1	4	8
4. Is muscle pain or stiffness greater in the morning than other times of the day?	0	1	4	8
5. Specific points on body feel sore when pressed	0	1	4	8
6. Feel unrefreshed upon awakening	0	1	4	8
7. Headaches	0	1	4	8
8. Pain at the sides of your head or in your face especially when awakening	0	1	4	8
9. Your jaw clicks or pops	0	1	4	8
10. Muscle twitch or tremor—eyelids, thumb, calf muscle	0	1	4	8
11. Irresistible urge to move legs	0	1	4	8
12. Legs move during sleep	0	1	4	8
13. Unpleasant crawling sensation inside calves when lying down	0	1	4	8
14. Hand and wrist numbness or pain (e.g., interferes with writing or with buttoning or unbuttoning your clothes)	0	1	4	8
15. Feeling of "pins and needles" in your thumb and first three fingers	0	1	4	8
16. Pain in forearm and sometimes in shoulder	0	1	4	8

Total points ____

PART X

SECTION A

1. Head feels heavy	0	1	4	8
2. Dizziness	0	1	4	8
3. Difficulty bending over, standing up from sitting, rolling over in bed and/or turning your head from side to side	0	1	4	8
4. Your hands tremble, ever so slightly, for no apparent reason	0	1	4	8
5. You feel like you're wearing heavy weights on your feet when walking	0	1	4	8
6. Bump into things, trip, stumble and feel clumsy	0	1	4	8
7. Difficulty breathing	0	1	4	8
8. Difficulty swallowing	0	1	4	8
9. People tell you to speak up because they have trouble hearing you	0	1	4	8
10. Speaking and forming words does not feel automatic	0	1	4	8
11. Need 10-12 hours of sleep to feel rested	0	1	4	8

PART X (cont.)

	No/Rarely	Occasionally	Often	Frequently
SECTION A *(cont.)*				
12. Lack strength (your grip is weak, holding your head or picking your arms up takes effort)	0	1	4	8
13. Hands get tired when you write and your handwriting is less legible and smaller than it used to be	(0)No			(8)Yes
14. Muscles in arms and legs seem softer and smaller	(0)No			(8)Yes
15. Is your eyesight, sense of smell and taste or ability to hear not as sharp as it used to be?	(0)No			(8)Yes
16. Do you find yourself moving slower than you used to?	(0)No			(8)Yes
Total points				
SECTION B				
1. Difficulty absorbing new information	0	1	4	8
2. Tend to forget things	0	1	4	8
3. Trouble thinking or concentrating	0	1	4	8
4. Easily distracted	0	1	4	8
5. Do you have a tendency to become frustrated quickly?	0	1	4	8
6. Inability to sit still for any length of time, even at mealtime	0	1	4	8
7. Finishing tasks is easier said than done	0	1	4	8
8. Do you have more trouble solving problems or managing your time than usual?	0	1	4	8
9. Low tolerance for stress and otherwise ordinary problems	0	1	4	8
Total points				

PART XI

Men Only

1. Sensation of not emptying your bladder completely	0	1	4	8
2. Need to urinate less than 2 hours after you have finished urinating	0	1	4	8
3. Find yourself needing to stop and start again several times while urinating	0	1	4	8
4. Find it difficult to postpone urination	0	1	4	8
5. Have a weak urinary stream	0	1	4	8
6. Need to push or strain to begin urinating	0	1	4	8
7. Dripping after urination	0	1	4	8
8. Urge to urinate several times a night	0	1	4	8
Total points				

PART XII

Women Only

(Menopausal women should skip to Sections E and F)

SECTION A

Do you persistently experience any of these symptoms within three days to two weeks *prior to menstruation?*

	No/Rarely	Occasionally	Often	Frequently
[A]				
1. Anxious, irritable or restless	(0)No			(8)Yes
2. Numbness, tingling in hands and feet	(0)No			(8)Yes
3. Easy to anger, resentful	(0)No			(8)Yes
4. Aggressive or hostile toward family/friends	(0)No			(8)Yes
SECTION A *(cont.)*				
[B]				
5. Abdominal bloating, feeling swollen (e.g., feet)	(0)No			(8)Yes
6. Temporary weight gain	(0)No			(8)Yes
7. Breast tenderness, swelling	(0)No			(8)Yes
8. Appearance of breast lumps	(0)No			(8)Yes
9. Discharge from nipples	(0)No			(8)Yes
10. Nausea and/or vomiting	(0)No			(8)Yes
11. Diarrhea or constipation	(0)No			(8)Yes
12. Aches and pains (back, joints, etc.)	(0)No			(8)Yes
[C]				
13. Craving for sweets	(0)No			(8)Yes
14. Increased appetite or binge eating	(0)No			(8)Yes
15. Headaches	(0)No			(8)Yes
16. Being easily overwhelmed, shaky or clumsy	(0)No			(8)Yes
17. Heart pounding	(0)No			(8)Yes
18. Dizziness or fainting	(0)No			(8)Yes
[D]				
19. Confused and forgetful to the point that work suffers	(0)No			(8)Yes
20. Overwhelmed with feelings of sadness and worthlessness	(0)No			(8)Yes
21. Difficulty sleeping or falling asleep	(0)No			(8)Yes
22. Engaging in self-destructive behavior	(0)No			(8)Yes
Total points				

SECTION B

Do you experience any of these symptoms *during your period?*

1. Cramping in lower abdomen or pelvic area	(0)No			(8)Yes
2. Lower abdominal pain is sharp and/or dull or intermittent	(0)No			(8)Yes
3. Bloating and sense of abdominal fullness	(0)No			(8)Yes
4. Diarrhea or constipation	(0)No			(8)Yes
5. Nausea and/or vomiting	(0)No			(8)Yes
6. Low back and/or legs ache	(0)No			(8)Yes
7. Headaches	(0)No			(8)Yes
8. Unusual fatigue (take naps) resulting in missed work	(0)No			(8)Yes
9. Painful and/or swollen breasts	(0)No			(8)Yes
10. Scanty blood flow	(0)No			(8)Yes
Total points				

SECTION C

1. Painful or difficult sexual intercourse	0	1	4	8
2. Low abdominal, back and vaginal pain throughout the month	0	1	4	8
3. Pelvic pressure or pain while sitting down or standing up, relieved by lying down	0	1	4	8
4. Vaginal bleeding other than during your period	0	1	4	8
5. Painful bowel movements	0	1	4	8
6. Difficult (straining) urination	0	1	4	8
7. Abnormal vaginal discharge	0	1	4	8
8. Offensive vaginal discharge	0	1	4	8
9. Vaginal itching or burning with or without intercourse	0	1	4	8
10. Pain during periods is getting progressively worse	(0)No			(8)Yes
11. Profuse or prolonged menstrual bleeding	(0)No			(8)Yes
12. Unable to get pregnant	(0)No			(8)Yes
Total points				

PART XII (cont.)

SECTION D

	No/Rarely	Occasionally	Often	Frequently
1. Absence of periods for six months or longer	(0)No			(8)Yes
2. Periods occur irregularly (e.g., 3 to 6 times a year)	(0)No			(8)Yes
3. Profuse heavy bleeding during periods	0	1	4	8
4. Menstrual blood contains clots and tissue	0	1	4	8
5. Bleeding between periods can occur anytime	0	1	4	8
6. Periods occur greater than every 35 days	(0)No			(8)Yes
7. Intense upper stomach pain, lasting several hours at the time you ovulate (approximately day 14 of your cycle)	0	1	4	8
8. Bleeding occurs at ovulation (approximately day 14 of your cycle)	0	1	4	8
9. Monthly abdominal pain without bleeding	0	1	4	8
10. Abundant cervical mucus	0	1	4	8
11. Acne and/or oily skin	0	1	4	8
12. Overwhelming urges for sexual intercourse	0	1	4	8
13. Aggressive feelings	0	1	4	8
14. Increased growth of dark facial and/or body hair	(0)No			(8)Yes
15. Poor sense of smell	(0)No			(8)Yes
16. Voice is becoming deeper	(0)No			(8)Yes
17. Breasts seem to be getting smaller	(0)No			(8)Yes
18. Receding hairline	(0)No			(8)Yes
Total points				

SECTION E

	No/Rarely	Occasionally	Often	Frequently
1. Vaginal discharge	0	1	4	8
2. Vaginal secretions are watery and thin	0	1	4	8
3. Vaginal dryness	0	1	4	8
4. Sexual intercourse is uncomfortable	0	1	4	8

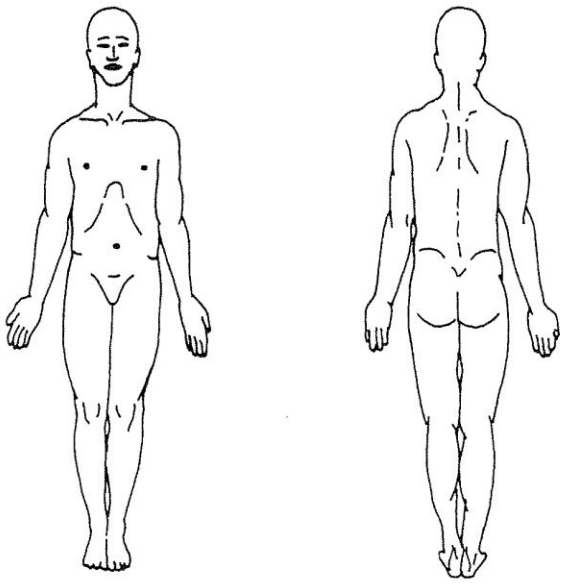
SECTION E (cont.)

	No/Rarely	Occasionally	Often	Frequently
5. Interest in having sex is low	0	1	4	8
6. Engorged breasts	0	1	4	8
7. Breast tenderness, soreness	0	1	4	8
8. Difficulty with orgasm	0	1	4	8
9. Vaginal bleeding after sexual intercourse	0	1	4	8
10. Do you skip periods?	(0)No			(8)Yes
11. The length (number of days) of your period varies month to month, with the number of days of bleeding getting fewer	(0)No			(8)Yes
Total points				

SECTION F

	No/Rarely	Occasionally	Often	Frequently
1. Sense of well-being fluctuates throughout the day for no apparent reason	0	1	4	8
2. Sudden hot flashes	0	1	4	8
3. Spontaneous sweating	0	1	4	8
4. Chills	0	1	4	8
5. Cold hands and feet	0	1	4	8
6. Heart beats rapidly or feels like it is fluttering	0	1	4	8
7. Numbness, tingling or prickling sensations	0	1	4	8
8. Dizziness	0	1	4	8
9. Mental fogginess, forgetful or distracted	0	1	4	8
10. Inability to concentrate	0	1	4	8
11. Depression, anxiety, nervousness and/or irritability	0	1	4	8
12. Difficulty sleeping	0	1	4	8
13. Conscious of new feelings of anger and frustration	0	1	4	8
14. Skin, hair, vagina and/or eyes feel dry	0	1	4	8
15. Stopped menstruating around six months ago, yet still experience some vaginal bleeding	(0)No			(8)Yes
Total points				

Please mark an "X" to indicate areas where you feel pain, swelling or discomfort, or areas of your skin that have changed color or texture (e.g., moles, rashes, etc.). Describe what you feel or observe in your own words. Write anywhere in this area.



Male Consultation Patient Symptoms Sheet

Rate your current status for each symptom by circling the appropriate number. Please feel free to use additional space to describe any symptom. This section may be repeated on subsequent visits.

	Mild	to	Severe
Headaches	**1**	**3**	**5**
Anxiety	**1**	**3**	**5**
Moodiness	**1**	**3**	**5**
Depressed Moods	**1**	**3**	**5**
Irritability, Anger, Temper	**1**	**3**	**5**
Emotional Swings	**1**	**3**	**5**
Insomnia	**1**	**3**	**5**
Fuzzy Thinking	**1**	**3**	**5**
Short-term Memory Loss	**1**	**3**	**5**
Food Cravings (salty or sweet)	**1**	**3**	**5**
Weight Gain (especially around the middle)	**1**	**3**	**5**
Shortness of Breath	**1**	**3**	**5**
Low Libido	**1**	**3**	**5**
Difficulty Starting an Erection (or No Erection)	**1**	**3**	**5**
Difficulty Maintaining Erections	**1**	**3**	**5**
Loss of Erections	**1**	**3**	**5**
Ejaculatory Problems	**1**	**3**	**5**
Dry Hair/Skin (especially hands and face)	**1**	**3**	**5**

Hair Loss	**1**	**3**	**5**
Loss of Pubic Hair	**1**	**3**	**5**
Frequent Urinary Tract Infections	**1**	**3**	**5**
Heart Palpitations	**1**	**3**	**5**
Fatigue, Lack of Energy	**1**	**3**	**5**
Bladder Symptoms	**1**	**3**	**5**
Symptoms of Low Thyroid (decreased metabolism)	**1**	**3**	**5**
Symptoms of Low Sugar (shakiness, lightheadedness before next meal)	**1**	**3**	**5**

OKULEY'S PHARMACY

Medical Equipment • Specialty Medications

Retail Prescriptions

Physician Medical Release Authorization

"I hereby authorize my Physician to furnish and agent of Okuley's Pharmacy and Home Medical any and all records pertaining to my medical history, services rendered and/or treatments. I understand that employees of Okuley's Pharmacy and Home Medical will protect my privacy and this information will be released to other health care professionals only when it is necessary in order to provide health care services to me. I further understand that an Okuley's Pharmacy and Home Medical employee will not release this information unless authorized by me in writing. This authority shall continue until revoked by me in writing."

Physician Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Patient Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Signature: _____

Patient Name:	SS#:

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Continental • P.O. Box 388, Continental, OH 45831 • (419) 596-3898 • Fax (419) 596-3909

Medical History Form-Male

Please return your form to the Pharmacy when you have finished.
The Pharmacist will meet with you to review your information. Thank you.

PATIENT INFORMATION: **TODAY'S DATE: _____**

Name: _____ Birth Date: _____
Address: _____ Age: _____
City: _____ Phone: _____
Occupation: _____ Wk Phone: _____

Living Situation: Spouse Alone Partner Friend(s) Parent Children Other

Status: Married Divorced Widowed Blood Type: O A B AB

How did you hear about our Pharmacy? _____

MEDICAL STATUS

How do you rate your general health? Excellent; Good; Fair Poor.

Height: _____ft._____in.; Weight: _____lbs

Blood pressure: _____ Pulse: _____

Lifestyle Information:		
	Do you use: Yes or No	If yes, **how often and how much?**
Tobacco (smoke, chew, dip)		
Alcohol (beer, wine, hard liquor)		
Caffeine (cola drinks, tea, coffee)		

IMPAIRMENTS: Check if you have any of the following:
_____ Physical impairment _____ Visual impairment _____ Hearing impairment

EXERCISE: Do you exercise regularly? YES NO
If YES, describe what you do and how often:

STRESS MANAGEMENT: Do you practice any stress management techniques?
YES NO If YES, describe what you do and how often.

SLEEP: How long does it take you to fall asleep? Minutes: 5 10 15 30 60+
Generally, how many hours of sleep do you get per night? _____ hours

Do you sleep uninterrupted all night? YES NO

If NO, how many times do you awaken: _____ times. Do you awaken at a particular time(s)?

What awakens you? _____

Do you nap during the day? YES NO How often and how long do you nap?

DIET: Describe your typical daily food intake:

First Meal: **Second Meal:** **Third Meal:** **Any Snacks/Other:**

DOCTOR INFORMATION: Are you currently under the care of a physician? YES NO
If YES, please list each doctor from whom you seek care, including address and phone number, if known:

Doctor Name: _____ Address: _____ Phone: _____

Doctor Name: _____ Address: _____ Phone: _____

Doctor Name: _____ Address: _____ Phone: _____

ALLERGIES: Please check all that apply:

_____penicillin _____morphine _____dye allergies _____pet allergies
_____codeine _____aspirin _____nitrate allergy _____seasonal(pollen)allergies
_____sulfa drug _____food allergies _____no known allergies Other: _____
Please describe the allergic reaction you experienced and when it occurred:

MEDICAL CONDITIONS/DISEASES:

Please check all that apply to you.

___Heart disease (ex. Congestive Heart Failure)
___High cholesterol or lipids (ex. Hyperlipidemia)
___High blood pressure (ex. Hypertension)
___Cancer
___Ulcers (stomach, esophagas)
___Thyroid disease
___Hormonal related Issues
___Blood Clotting Problems

___Lung condition (ex. Asthma, Emphysema, COPD)
___Diabetes
___Arthritis or joint problems
___Depression
___Epilepsy
___Headaches/migraines
___Eye disease (glaucoma, etc.)
___Other. Please list: _____

FAMILY HISTORY: Do you have a family history of any of the following?

LIVING	IMPORTANT DISEASES
Mother	
Father	
Brothers	
Sisters	
Aunts	
Uncles	
Paternal Grandmother	
Paternal Grandfather	
Maternal Grandmother	
Paternal Grandfather	

DECEASED	IMPORTANT DISEASES
Mother	
Father	
Brothers	
Sisters	
Aunts	
Uncles	
Paternal Grandmother	
Paternal Grandfather	
Maternal Grandmother	
Paternal Grandfather	

OVER-THE-COUNTER (OTC) ISSUES:

Please check all products that you use occasionally or regularly.

___Pain Reliever

- ___Acetaminophen (ex. Tylenol®)
- ___Ibuprofen (ex. Motrin IB ®)
- ___Naproxen (ex. Aleve®)
- ___Ketoprofen (ex. Orudis KT ®)

___Cough Suppressant (ex. Robitussin DM ®)
___Antihistamine product (ex. Chlor-Trimenton®)
___Decongestant product (ex. Sudafed ®0
___Combination product (cough & cold reliever) (ex. Triaminic DM ®)
___Sleep aids (ex. Excedrin PM ®, Unisom ®, Sominex ®, Nytol ®)

___Antidiarrheals (ex. Imodium ®, Pepto Bismol ®, Kaopectate ®)
___Laxative/Stool Softeners (ex. Doxidan ®, Correctol ®, etc.)
___Diet aids/Weight loss products (ex. Dexatrim ®)
___Antacids (ex. Maalox ®, Mylanta ®)
Acid Blockers (ex. Tagament HB ®, Pepcid AC ®, Zantac 75 ®)
___Other (please list): _____
_____
_____
_____

MEDICAL CONDITIONS/DISEASES:

Please check all that apply to you.

___Heart disease (ex. Congestive Heart Failure)
___High cholesterol or lipids (ex. Hyperlipidemia)
___High blood pressure (ex. Hypertension)
___Cancer
___Ulcers (stomach, esophagas)
___Thyroid disease
___Hormonal related Issues
___Blood Clotting Problems

___Lung condition (ex. Asthma, Emphysema, COPD)
___Diabetes
___Arthritis or joint problems
___Depression
___Epilepsy
___Headaches/migraines
___Eye disease (glaucoma, etc.)
___Other. Please list: _____

TOP THREE BIGGEST CONCERNS/SYMPTOMS:

1. _____ Since When: _____
2. _____ Since When: _____
3. _____ Since When: _____

Circle the answer that best describes you.

Sexual Function

Decreased libido or desire for sex

Rare Moderate Frequent Severe

Loss of morning erections

Rare Moderate Frequent Severe

Difficulty maintaining erections

Rare Moderate Frequent Severe

Difficulty starting an erection/No erection

Rare Moderate Frequent Severe

Ejaculation potency problems-decreased volume of ejaculate and ejaculatory force

Rare Moderate Frequent Severe

Mental Function

Feeling of burn out/inability to concentrate

Rare Moderate Frequent Severe

Tiredness, fatigue, and loss of energy

Rare Moderate Frequent Severe

Decreased mental sharpness and attention

Rare Moderate Frequent Severe

Forgetfulness

Rare Moderate Frequent Severe

Feeling of depression-important things, such as marriage and work, have lost significance

Rare Moderate Frequent Severe

Increased irritability, anger, and bad temper

Rare Moderate Frequent Severe

Musculoskeletal Condition

Decreased physical stamina

Rare Moderate Frequent Severe

Decreased Muscle size, tone and strength

Rare Moderate Frequent Severe

"Sore-body syndrome"-aches and pains in muscles and joints

Rare Moderate Frequent Severe

Development of osteoporosis or arthritis

Rare Moderate Frequent Severe

Metabolic or Physical/Disease Problems

Increased total cholesterol and triglycerides

Rare Moderate Frequent Severe

Diabetes onset/Rise in blood sugar

Rare Moderate Frequent Severe

Increased blood pressure

Rare Moderate Frequent Severe

Increased waist size-weight gain especially around the middle

Rare Moderate Frequent Severe

Increased fat in the breast and hip areas

Rare Moderate Frequent Severe

Dry skin on the hands and face

Rare Moderate Frequent Severe

Age you are: _____

Age you feel: _____

What four (4) symptoms do you most want to improve or correct?

1. **_____**
2. **_____**
3. **_____**
4. **_____**

QUESTION DOCUMENTATION FORM

Please write down any questions you may have about Prescription Bio-Identical Hormone Replacement Therapy (RxBHRT), other medications, or any other questions that come up as you read through the materials you have received. Bring this question sheet with you to your consultation so you can discuss this information with your pharmacist/nurse. Thank you.

1.

2.

3.

4.

5.

Medical History Form-Male

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City: _____ Phone: _____
Occupation: _____ Wk Phone: _____

Living Situation: Spouse Alone Partner Friend(s) Parent Children Other

Status: Married Divorced Widowed Blood Type: O A B AB

How did you hear about our Pharmacy? _____

MEDICAL STATUS

How do you rate your general health? Excellent; Good; Fair Poor.

Height: _____ft._____in.; Weight: _____lbs

Blood pressure: _____ Pulse: _____

Lifestyle Information:		
	Do you use: Yes or No	If yes, **how often and how much?**
Tobacco (smoke, chew, dip)		
Alcohol (beer, wine, hard liquor)		
Caffeine (cola drinks, tea, coffee)		

IMPAIRMENTS: Check if you have any of the following:
_____ Physical impairment _____ Visual impairment _____ Hearing impairment

EXERCISE: Do you exercise regularly? YES NO
If YES, describe what you do and how often:

STRESS MANAGEMENT: Do you practice any stress management techniques?
YES NO If YES, describe what you do and how often.

SLEEP: How long does it take you to fall asleep? Minutes: 5 10 15 30 60+
Generally, how many hours of sleep do you get per night? _____ hours

Do you sleep uninterrupted all night? YES NO

If NO, how many times do you awaken: _____ times. Do you awaken at a particular time(s)?

What awakens you? _____

Do you nap during the day? YES NO How often and how long do you nap?

DIET: Describe your typical daily food intake:

First Meal: **Second Meal:** **Third Meal:** **Any Snacks/Other:**

DOCTOR INFORMATION: Are you currently under the care of a physician? YES NO
If YES, please list each doctor from whom you seek care, including address and phone number, if known:

Doctor Name: _____ Address: _____ Phone: _____

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_____penicillin _____morphine _____dye allergies _____pet allergies
_____codeine _____aspirin _____nitrate allergy _____seasonal(pollen)allergies
_____sulfa drug _____food allergies _____no known allergies Other: _____
Please describe the allergic reaction you experienced and when it occurred:

MEDICAL CONDITIONS/DISEASES:

Please check all that apply to you.

___Heart disease (ex. Congestive Heart Failure)
___High cholesterol or lipids (ex. Hyperlipidemia)
___High blood pressure (ex. Hypertension)
___Cancer
___Ulcers (stomach, esophagas)
___Thyroid disease
___Hormonal related Issues
___Blood Clotting Problems

___Lung condition (ex. Asthma, Emphysema, COPD)
___Diabetes
___Arthritis or joint problems
___Depression
___Epilepsy
___Headaches/migraines
___Eye disease (glaucoma, etc.)
___Other. Please list: _____

FAMILY HISTORY: Do you have a family history of any of the following?

LIVING	IMPORTANT DISEASES
Mother	
Father	
Brothers	
Sisters	
Aunts	
Uncles	
Paternal Grandmother	
Paternal Grandfather	
Maternal Grandmother	
Paternal Grandfather	

DECEASED	IMPORTANT DISEASES
Mother	
Father	
Brothers	
Sisters	
Aunts	
Uncles	
Paternal Grandmother	
Paternal Grandfather	
Maternal Grandmother	
Paternal Grandfather	

OVER-THE-COUNTER (OTC) ISSUES:

Please check all products that you use occasionally or regularly.

___Pain Reliever

- ___Acetaminophen (ex. Tylenol®)
- ___Ibuprofen (ex. Motrin IB ®)
- ___Naproxen (ex. Aleve®)
- ___Ketoprofen (ex. Orudis KT ®)

___Cough Suppressant (ex. Robitussin DM ®)
___Antihistamine product (ex. Chlor-Trimenton®)
___Decongestant product (ex. Sudafed ®0
___Combination product (cough & cold reliever) (ex. Triaminic DM ®)
___Sleep aids (ex. Excedrin PM ®, Unisom ®, Sominex ®, Nytol ®)

___Antidiarrheals (ex. Imodium ®, Pepto Bismol ®, Kaopectate ®)
___Laxative/Stool Softeners (ex. Doxidan ®, Correctol ®, etc.)
___Diet aids/Weight loss products (ex. Dexatrim ®)
___Antacids (ex. Maalox ®, Mylanta ®)
Acid Blockers (ex. Tagament HB ®, Pepcid AC ®, Zantac 75 ®)
___Other (please list): _____
_____
_____
_____

MEDICAL CONDITIONS/DISEASES:

Please check all that apply to you.

___Heart disease (ex. Congestive Heart Failure)
___High cholesterol or lipids (ex. Hyperlipidemia)
___High blood pressure (ex. Hypertension)
___Cancer
___Ulcers (stomach, esophagas)
___Thyroid disease
___Hormonal related Issues
___Blood Clotting Problems

___Lung condition (ex. Asthma, Emphysema, COPD)
___Diabetes
___Arthritis or joint problems
___Depression
___Epilepsy
___Headaches/migraines
___Eye disease (glaucoma, etc.)
___Other. Please list: _____

TOP THREE BIGGEST CONCERNS/SYMPTOMS:

1. _____ Since When: _____
2. _____ Since When: _____
3. _____ Since When: _____

Circle the answer that best describes you.

Sexual Function

Decreased libido or desire for sex

Rare Moderate Frequent Severe

Loss of morning erections

Rare Moderate Frequent Severe

Difficulty maintaining erections

Rare Moderate Frequent Severe

Difficulty starting an erection/No erection

Rare Moderate Frequent Severe

Ejaculation potency problems-decreased volume of ejaculate and ejaculatory force

Rare Moderate Frequent Severe

Mental Function

Feeling of burn out/inability to concentrate

Rare Moderate Frequent Severe

Tiredness, fatigue, and loss of energy

Rare Moderate Frequent Severe

Decreased mental sharpness and attention

Rare Moderate Frequent Severe

Forgetfulness

Rare Moderate Frequent Severe

Feeling of depression-important things, such as marriage and work, have lost significance

Rare Moderate Frequent Severe

Increased irritability, anger, and bad temper

Rare Moderate Frequent Severe

Musculoskeletal Condition

Decreased physical stamina

Rare Moderate Frequent Severe

Decreased Muscle size, tone and strength

Rare Moderate Frequent Severe

"Sore-body syndrome"-aches and pains in muscles and joints

Rare Moderate Frequent Severe

Development of osteoporosis or arthritis

Rare Moderate Frequent Severe

Metabolic or Physical/Disease Problems

Increased total cholesterol and triglycerides

Rare Moderate Frequent Severe

Diabetes onset/Rise in blood sugar

Rare Moderate Frequent Severe

Increased blood pressure

Rare Moderate Frequent Severe

Increased waist size-weight gain especially around the middle

Rare Moderate Frequent Severe

Increased fat in the breast and hip areas

Rare Moderate Frequent Severe

Dry skin on the hands and face

Rare Moderate Frequent Severe

Age you are: _____

Age you feel: _____

What four (4) symptoms do you most want to improve or correct?

1. **_____**
2. **_____**
3. **_____**
4. **_____**

QUESTION DOCUMENTATION FORM

Please write down any questions you may have about Prescription Bio-Identical Hormone Replacement Therapy (RxBHRT), other medications, or any other questions that come up as you read through the materials you have received. Bring this question sheet with you to your consultation so you can discuss this information with your pharmacist/nurse. Thank you.

1.

2.

3.

4.

5.

Okuley's Pharmacy New Patient Information

Date: _____

Patient Information

Name: _____

Address: _____

_____

Phone number: _____

Date of Birth: _____

Doctor's Information

Name: _____ Phone Number: _____

Medication Information

Allergies:

Allergic to What	Reaction

Current Medications:

Medication	Strength	Medication	Strength

Herbal/Over-the-Counter/Nutritional Products:

Product	Taken How Often	Product	Taken How Often

Diseases/Conditions

Disease/Condition	Year Diagnosed	Disease/Condition	Year Diagnosed

**Please provide your prescription insurance card before we fill your prescription*

OKULEY'S PHARMACY

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Retail Prescriptions

PHOTO CONSENT

I freely give my consent to have my picture taken and be used by Okuley's Pharmacy and Home Medical for my patient file.

Printed Name: _____

Signature: _____

Date: _____

Witness: _____

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Lab Work

Levels of hormones can be helpful in evaluating your replacement needs. We suggest that you have your physician get base line levels of your hormones **before** starting human bio-identical hormone replacement.

Levels can be checked by either blood or saliva sample. If you prefer to have saliva testing, please contact the pharmacy for a saliva kit. Blood levels will have to be drawn at your physician's office.

The following labs are what we suggest you have drawn or collected:

Males:

Testosterone Free
DHEA-sulfate
SHBG
Estradiol
LH
PSA
Cortisol—4 point (If under a lot of stress)
Thyroid (T4 total and free, T3 total and free, TSH, Vit D 25, Vit D 25 OH, Ferritin) (if tired, constipated, cold blooded, depressed, or experiencing weight gain)
Lipid Panel