The Medicine Shoppe® PHARMACY

Caring beyond prescriptions.℠

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Date_____

Male Patient Information and Health Summary

Name_____ Date of Birth _____

Address_____City/State/ZIP_____

Home Phone (_____)-_____-_____ Cell Phone (_____)-_____-_____

Who referred you to us? _____

Please List Your Healthcare Providers & Indicate Which Doctor to Contact Regarding Hormone Therapy

Name_____ Name_____

Specialty _____ Specialty_____

Location _____ Location_____

Phone _____ Phone_____

Fax_____ Fax_____

Insurance Information:

Plan Name _____ BIN# _____PCN# _____

ID# _____ Pharmacy Group# _____

Who is the main cardholder? _____ Your member# _____

Any Known Medication Allergies_____

Please List Any Medications You Are **CURRENTLY** Taking, **Including Hormones (With Strengths),** Vitamins, Natural Supplements, or Non-Prescription Medications: _____

_____

_____

_____

Please List Any **PREVIOUS** Hormones Taken, Doses, Any Side Effects, and How Long Ago They Were Discontinued:_____

_____

_____

Have You Tried Alternative Therapies or Taken Any Herbal or Homeopathic Products?

_____

How Did You Become Interested in Bio-Identical Hormones? _____

_____

Is Your **Diet:** 1 Bad 2 Fair 3 Good 4 Very Good (please circle)

Exercise: Type of Activity, How Frequent, and For How Long?_____

_____

Employer and Job Title _____

Circle Your Perceived Stress Level: 1 None 2 Mild 3 Moderate 4 Severe 5 Extremely Severe

Family History

Please Check All That Apply:

___ Cancer (type)

___ Breast_____	Relationship to You_____
___ Uterine_____	Relationship to You_____
___ Ovarian_____	Relationship to You_____
___ Other_____	Relationship to You_____
___ Diabetes; type_____	Relationship to You_____
___ Heart Disease_____	Relationship to You_____
___ Osteoporosis_____	Relationship to You_____
___ Alzheimer's Disease_____	Relationship to You_____
___ Thyroid Disease_____	Relationship to You_____

Past or Present Medical Conditions

Please check all that apply:

___ Asthma	___ Fibromyalgia	___ Fractures _____
___ Cancer (type:_____	___ Arthritis	___ Epilepsy
___ Depression	___ Varicose Veins	___ Liver Disorder
___ Diabetes (type:_____)	___ Kidney Disorder	___ Eating Disorder
___ Headaches/Migraines	___ Thyroid Disorder	___ Ulcers
___ Heart Condition _____	___ High Cholesterol	___ Chronic Fatigue Syndrome
___ High Blood Pressure	___ Clotting Disorder	___ Other _____
___ Osteoporosis/Osteopenia	___ Gallbladder Disease	

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Have you ever had . . . (check all that apply)

___ Difficulty Achieving Erection	___ Lack of Sex Drive	___ Painful Intercourse
___Lack of Energy	___Genital Warts	___ Inability to Reach Climax

Please Check All Symptoms Below That Apply (this is very important to the evaluation process)

Symptoms of **Low Progesterone**?

__ Acne
__ Anxiety/Irritability
__ Weight Gain
__ Mood Swings
__ Food Cravings
__ Joint Pain
__ Headaches
___per week
__ Low Sex Drive
__ Depression
__ Fuzzy Thinking
__ Low Energy

Other symptoms?

__ Insomnia

Symptoms of **Low Testosterone?**

__ Depression
__ Erectile Dysfunction
__ Joint Pain
__ Heart Palpitations
__ Fibromyalgia
__ Urinary Incontinence
__ Low Sex Drive
__ Thinning Skin
__ Inability to Climax
__ Low Energy __ Bone Loss
__ Memory Lapses
__ Muscle Weakness

Other Symptoms_____

Top 3 symptoms you'd like resolved: _____

Directions: Circle the number that best describes the DEGREE of symptom intensity you have experienced over the past month(s)

None	Mild	Moderate	Severe
0	1	2	3

1. Insomnia or Restless, Fragmented Sleep?

0 1 2 3

2. Irritability, Feeling Anxious or Apprehensive?

0 1 2 3

3. Feeling of Depression and Unhappiness and/or Being Miserable Without Obvious Reason?

0 1 2 3

4. Sensations of Dizziness or Swimming in the Head?

0 1 2 3

5. Feeling of Weariness of Mind and Body Associated with Desire for Rest; Disinclination to Make Further Efforts?

0 1 2 3

6. Pain of Any Kind Affecting Joints or Muscles?

0 1 2 3

7. Headaches of Any Kind (Tension, Migraine, etc)?

0 1 2 3

8. Quickening or Acceleration of Heartbeat or Fluttering/Pounding Heartbeat in a Sitting or Resting Position?

0 1 2 3

Have you ever had . . .

Never	Infrequently	Sometimes	Most of Time	Always
0	**1**	**2**	**3**	**4**

1. Painful Urination or Increased Frequency or Urination?

0 1 2 3 4

2. Leaking of Urine When Coughing, Laughing, Sneezing, or on Hard Work?

0 1 2 3 4

3. Leaking of Urine When Walking, Running, Climbing Steps, or on Light Work?

0 1 2 3 4

4. Leaking of Urine, Regardless of Activity, Even When in a Lying Position?

0 1 2 3 4

BHRT Compounded Medication Agreement

Please Initial

_____ I authorize the staff at The Medicine Shoppe to review my information and use this information to contact my physician's office for approval of BHRT compounded medication(s).

_____ I understand that I will be required to give a credit card number for prepayment prior to my first fill of any compounded medication(s) and this card will only be charged subsequently if I request it to be used **OR** fail to pick up a refill that I have requested to have made.

_____ I understand that every individual's body is different, and while the pharmacy can generally get close with my first prescription, it is normal to require further "tweaking" of my doses.

_____ I understand that if I have had 2 or 3 dose changes already, it may be necessary to get labs done for clarity. Saliva testing is preferred by the pharmacists (especially when using a topical cream), but blood work is welcome.

_____ I understand that I will need to give any dose adjustment on my hormones 4 to 6 weeks for my body to adjust before requesting further adjustments to be made.

_____ I understand that I need to call refills in **at least 5 business days (Monday-Friday)** to avoid running out before my compound is ready **(or longer if the doctor needs to be called for refills or if I ask for it to be mailed).** Most of the time it will only take 2 or 3 days, however, some compounds take longer than others to make.

_____ I understand that if, for any reason, I need to pick up my compound sooner than 5 days after requesting it, there is a **RUSH** option for a **$25 fee** to have it put in front of other compounds already in the lab. This will ensure it is the next compound in line.

_____ I understand that the pharmacist may not be available and will need to call me back after pulling my chart when I call with questions about symptoms/medications.

_____ I understand that an updated symptom update sheet will be requested each time I wish to have a change made to my compound.

_____ I understand that if I need to speak with the pharmacist for more than 5 to 10 minutes (which is free of charge), I will need to schedule a one-on-one consultation and that there is a fee of $50 per 30 minutes for this service.

_____ I understand that The Medicine Shoppe will call me when my compound is ready to pick up (if I request it to be mailed, then they will mail it without calling). If I have not received a call in 5 days, I should call and check on the status.

X _____ **Date** _____

Patient Signature