

CURTIS PHARMACY

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MALE CONFIDENTIAL HORMONE EVALUATION MEDICAL HISTORY

Please fill out the information completely, then fax or mail to Curtis Pharmacy.
Our Hormone Specialist will then contact you to schedule your consultation either in person or by phone.

Today's Date: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-Mail Address: _____

Gender: Male Female Height: _____ Weight: _____

Bone Size: Small Medium Large

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

Allergies: Please check all that apply.

___ penicillin ___ morphine ___ dye allergies ___ pet allergies
___ codeine ___ aspirin ___ nitrate allergy ___ seasonal (pollen)
___ 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 (example: Congestive Heart Failure) ___ Blood Clotting Problems
___ High cholesterol or lipids ___ Diabetes
___ High blood pressure (example: Hypertension) ___ Arthritis or joint problems
___ Cancer _____ ___ Depression
___ Ulcers (stomach, esophagus) ___ Epilepsy
___ Thyroid disease ___ Headaches/migraines
___ Hormonal related issues ___ Eye Disease (glaucoma, etc.)
___ Lung condition (example: asthma, emphysema, COPD) ___ Osteoporosis
___ Erectile Dysfunction ___ Other: Please list: _____

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

Breast Cancer	_____	Family member(s)	_____
Heart Disease	_____	Family member(s)	_____
Osteoporosis	_____	Family member(s)	_____
Thyroid Disease	_____	Family member(s)	_____

Current Prescription Medications:

Medication Name	Strength	Date Started	How often per day
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List Hormones previously taken.	Date Started	Date Stopped	Reason Stopped
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Over-the-counter (OTC) issues:

Please check all products that you use occasionally or regularly. Check all that apply.

- | | |
|--|---|
| <input type="checkbox"/> Pain Reliever | <input type="checkbox"/> Combination product (cough+cold reliever)(example: Triaminic DM) |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Sleep aids (exmples: Excedrin PC, Unisom, Sominex, Nytol) |
| <input type="checkbox"/> Acetaminophen (example: Tylenol) | <input type="checkbox"/> Antidiarrheals (examples:Imodium®, Pepto Bismol, Kaopectate) |
| <input type="checkbox"/> Ibuprofen (example: Motrin IB) | <input type="checkbox"/> Laxatives/stool softeners (examples: Doxidan, Correctol®, etc.) |
| <input type="checkbox"/> Naproxen (example: Aleve) | <input type="checkbox"/> Diet aids/weight loss products (example: Dexatril) |
| <input type="checkbox"/> Ketoprofen (example: Orudis KT) | <input type="checkbox"/> Antacids (examples: Maalox, Mylanta) |
| <input type="checkbox"/> Cough suppressant (ex: Robitussin DM) | <input type="checkbox"/> Acid blockers (examples: Tagamet HB, Pepcid C, Zantac 75) |
| <input type="checkbox"/> Antihistamine product (ex: Chlor-Trimeton, Claritin, Zyrtec, Allegra) | |
| <input type="checkbox"/> Decongestant product (example: Sudafed ®) | |
| <input type="checkbox"/> Other: _____ | |

Nutritional/Natural Supplements: Please identify and list the products you are using:

- vitamins (examples: multiple or single vitamins such as B complex, E, C, beta carotene)
- minerals (examples: calcium, magnesium, chromium, colloidal minerals, various single minerals)
- herbs (examples: Ginseng, Ginkgo Biloba, Echinacea, other herbal medicinal teas, tinctures, remedies, etc.)
- enzymes (examples: digestive formulas, papaya, bromelain, CoEnzyme Q10, etc.)
- nutrition/protein supplements (examples: shark cartilage, protein powers, amino acids, fish oils, etc.)
- others (glucosamine, etc.) _____

List use of:		Qty.	Daily	Weekly	Monthly	Occasionally
Tobacco?	<input type="checkbox"/> NO <input type="checkbox"/> YES	___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol?	<input type="checkbox"/> NO <input type="checkbox"/> YES	___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caffeine?	<input type="checkbox"/> NO <input type="checkbox"/> YES	___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you had a vasectomy? No Yes Date: _____

Have you ever been treated for Prostate Cancer? No Yes Date: _____

Has a physician ever suggested you may have an enlarged prostate? No Yes

Where did you receive the information to consider Bio-identical Hormone Restoration Therapy? Doctor Self Friend/Family Member Other

What are your goals with taking BHRT?

Please write down any questions you have about Bio-Identical Hormone Replacement Therapy.

Please rate the following symptoms as they apply to you.

Symptoms Analysis				
Symptoms	Absent	Mild	Moderate	Severe
Acne				
Aggressive Behavior				
Allergies				
Anxious				
Apathy				
Bone Loss				
Burned Out Feeling				
Cold Body Temperature				
Constipation				
Decreased Erections				
Decreased Flexibility				
Decreased Libido				
Decreased Mental Sharpness				
Decreased Muscle Size				
Decreased Stamina				
Decreased Sweating				
Decreased Urine Flow				
Depressed				
Difficulty Sleeping				
Dizzy Spells				
Elevated Triglycerides				
Evening Fatigue				
Goiter				
Hair Dry or Brittle				
Headaches				
Hearing Loss				
Heart Palpitations				
High Blood Pressure				
High Cholesterol				
Hoarseness				
Hot Flashes				
Increased Forgetfulness				
Increased Joint Pain				
Increased Urinary Urge				
Infertility Problems				
Irritable				
Low Blood Pressure				
Low Blood Sugar				
Mental Fatigue				
Morning Fatigue				
Nails Breaking or Brittle				
Neck or Back Pain				
Nervous				
Night Sweats				
Numbness-Feet/Hands				
Oily Skin or Hair				
Other				
Prostate Problems				
Rapid Heartbeat				
Ringing In Ears				
Sensitivity To Chemicals				
Slow Pulse Rate				
Sore Muscles				
Rapid Aging				
Stress				
Sugar Craving				
Swelling or Puffy Eyes/Face				
Thinning Skin				
Weight Gain - Breast or Hips				
Weight Gain - Waist				
The age you are:				
The age you feel:				