PPreckshot
PROFESSIONAL PHARMACY

Hormone Consultation for Men

Patient Name Today's Date

Birth Date Phone

Address

City State Zip

E-mail

Marital Status Weight

Occupation Height

Allergies (Please check all that apply)

- ☐ Penicillin
- ☐ Codeine
- ☐ Sulfa Drugs
- ☐ Morphine
- ☐ Aspirin
- ☐ Food Allergies
- ☐ Dye Allergies
- ☐ Nitrate Allergy
- ☐ Pet Allergies
- ☐ Seasonal Allergies
- ☐ Food Allergy
- ☐ Dairy Allergy
- ☐ Other

If you selected other, what other allergies do you suffer from?

Please describe any allergic reactions you have experienced due to the selected fields above.

Physician Information: Please include Physician Name, Address & Phone

How did you arrive at the decision to consider bio-identical hormone replacement? (Check all that apply)

☐ Physician ☐ Self ☐ Friend/Family Member

☐ Other

Please indicate current prescription medications and nutritional supplements:
(Bring all medications and supplements with you to your scheduled consultation)

Name, Strength, How often, How many per day

Have you had any of the following tests performed in the past year? (Check all that apply)

	Yes	No	Normal	Abnormal
PSA	○	○	○	○
PSA (Normal or Abnormal)	○	○	○	○
Liver Function	○	○	○	○
Liver Function (Normal or Abnormal)	○	○	○	○
Testosterone	○	○	○	○
Testosterone (Normal or Abnormal)	○	○	○	○
Have you had a vasectomy? (Yes or No)	○	○	○	○

Medical Conditions / Diseases: Please check all the apply for you or an immediate family member.

Allergies / Asthma
- [ ] Self
- [ ] Family

Alzheimer's
- [ ] Self
- [ ] Family

Arthritis
- [ ] Self
- [ ] Family

Cancer
- [ ] Self
- [ ] Family

Clotting Disorder
- [ ] Self
- [ ] Family

Depression
- [ ] Self
- [ ] Family

Diabetes
- [ ] Self
- [ ] Family

Eczema
- [ ] Self
- [ ] Family

Fibrocystic Breast
- [ ] Self
- [ ] Family

Ulcer
- [ ] Self
- [ ] Family

Anxiety Disorder
- [ ] Self
- [ ] Family

Stroke
- [ ] Self
- [ ] Family

Heart Disease
- [ ] Self
- [ ] Family

High Cholesterol or Lipids
- [ ] Self
- [ ] Family

High Blood Pressure
- [ ] Self
- [ ] Family

Eye Disease
- [ ] Self
- [ ] Family

Migraines / Headaches
- [ ] Self
- [ ] Family

Osteoporosis
- [ ] Self
- [ ] Family

Thyroid Disease
- [ ] Self
- [ ] Family

Emphysema / COPD
- [ ] Self
- [ ] Family

Fibromyalgia
- [ ] Self
- [ ] Family

GERD
- [ ] Self
- [ ] Family

Seizure Disorder
- [ ] Self
- [ ] Family

Irritable Bowel
- [ ] Self
- [ ] Family

Liver Disorder
- [ ] Self
- [ ] Family

Please indicate your symptoms for the following conditions by using the following numeric scale:
1 being no symptoms at all to 5 being the worst symptoms imaginable.

	1	2	3	4	5
Arthritis, Painful Joints	○	○	○	○	○
Decrease in Athletic Performance & Competitiveness	○	○	○	○	○
Erection Issues	○	○	○	○	○
Fatigue, Loss of Energy	○	○	○	○	○
Decrease in Mental Sharpness	○	○	○	○	○
Decrease in Muscle Mass	○	○	○	○	○
Night Sweats / Hot Flashes	○	○	○	○	○
Osteoporosis	○	○	○	○	○
Short Term Memory Loss	○	○	○	○	○
Sleep Disorders, Insomnia	○	○	○	○	○
Anxiety	○	○	○	○	○
Breasts - Tender, Swollen	○	○	○	○	○
Headaches	○	○	○	○	○
Increased Irritability, Temper	○	○	○	○	○
Mood Swings	○	○	○	○	○
Decreased Sex Drive	○	○	○	○	○
Weight Gain, Increase in Waist Size	○	○	○	○	○
Decreased Urine Flow	○	○	○	○	○
Depression	○	○	○	○	○
Heartburn / Indigestion	○	○	○	○	○
Gas / Bloating	○	○	○	○	○
Irritable	○	○	○	○	○
Digestive Issues	○	○	○	○	○

Age you feel _____ Age you are _____

DIET: Read the following and circle the number that applies:
1 = Do not consume or use
2 = Consume or use 2 to 3 times monthly
3 = Consume or use weekly
4 = Consume or use daily

	1	2	3	4
Alcohol	○	○	○	○
Artificial Sweeteners	○	○	○	○
Candy, Desserts, Refined Sugar	○	○	○	○
Carbonated Beverages	○	○	○	○
Chewing Tobacco	○	○	○	○
Cigarettes	○	○	○	○
Cigars / Pipes	○	○	○	○
Caffeinated Beverages	○	○	○	○
Fast Foods	○	○	○	○
Fried Foods	○	○	○	○
Luncheon Meats	○	○	○	○
Margarine	○	○	○	○
Milk Products	○	○	○	○
Radiation Exposure (1 = No, 2 = Yes)	○	○	○	○
Refined Flour / Baked Goods	○	○	○	○
Vitamins and Minerals	○	○	○	○
Water, distilled	○	○	○	○
Water, tap	○	○	○	○
Water, well	○	○	○	○
Diet often for weight control	○	○	○	○

LIFESTYLE:

	1	2	3	4
Exercise per week (1=2 or more times a week, 2= 1 time a week, 3= 1 or 2 times a month, 4= never, less than once a month)	○	○	○	○
Changed jobs (1= over 12 months ago, 2= within last 12 months, 3= within last 6 months, 4= within last 2 months)	○	○	○	○
Divorced (1= never, over 2 years ago, 2= within last 2 years, 3= within last year, 4= within last 6 months)	○	○	○	○
Work over 60 hours/week (1=never, 2= occasionally, 3= usually, 4= always)	○	○	○	○

Have you previously taken any hormones? If so, please explain what you have taken and why you stopped.

What are your goals with taking BHRT?

Please indicate any specific questions you have about BHRT?

Are there any specific health concerns or issues you would like to discuss during your consultation?

I understand that my hormone consultation with Preckshot Professional Pharmacy is with a pharmacist who specializes in hormone therapy who will not diagnose or treat any medical condition, who will not replace the advice of my primary care physician in any way, who will work with my referring health care provider to alleviate my hormone related symptoms and who will help me to decide what nutritional supplements, if any, would be safe and appropriate.

Name:
(Please Print)

Signature

Date

Please fax or send this completed questionnaire to:
Phone: 309-679-2047 Fax: 309-679-2051
www.preckshot.com

Please bring any nutritional supplements, medications and lab reports with you at the time of your consultation.