Stanley Pharmacy Compounding Center
2413 West Beebe-Capps Expressway
Searcy, Arkansas 72143

Tel. (501) 305-4108 Fax (501) 305-4514

CONFIDENTIAL HORMONE EVALUATION--MALE

I understand that the fee for this consultation is $60.00. _____(initials)

I understand that insurance does not always cover compounded hormone replacement prescriptions, but Stanley Pharmacy will provide claim forms to turn in to request reimbursement._____(initials)

I acknowledge my understanding of the Health Insurance Portability and Accountability Act (HIPAA) and that I have been offered a copy of Stanley Pharmacy's Notice of Privacy Practices.

Signature_____ Initials _____

Who referred you to Stanley Pharmacy for hormone replacement?

_____

Today's Date: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Best Number to reach you_____

Place of Employment _____Height: _____ Weight: _____

Email Address_____

Insurance Information

Insurance Name: _____

Subscriber I. D. #: _____ Group #: _____

Cardholder Name: _____ Cardholder Birthdate _____

Doctor's Name **Address** **Phone**

_____

_____

Allergies: Please check all that apply.

___ penicillin ___ morphine ___ dye allergies ___ pet allergies
___ codeine ___ aspirin ___ nitrate allergy ___seasonal (pollen) allergies
___ sulfa drugs ___ food allergies ___no known allergies other: _____

Please describe the allergic reaction you experienced and when it occurred.

_____
_____
_____
_____

		How often & how much?
Do you use tobacco?	Yes/No	_____
Do you use alcohol?	Yes/No	_____
Do you use caffeine?	Yes/No	_____

Please list any OTC (Over-the-Counter) products that you use occasionally or regularly.
(i.e. pain relievers, sleep aids, vitamins, antacids, allergy medications, laxatives, or herbal supplements)

_____
_____
_____
_____

Please list all current medical conditions/diseases.
(I.e. high blood pressure, high cholesterol, diabetes, thyroid disease, migraines, depression, arthritis, asthma)

_____
_____
_____
_____
_____

Current Prescription Medications:

Medication Name Strength Date Started How often per day

_____
_____
_____
_____
_____

List Hormones previously taken Date started Date stopped Reason

_____
_____

What is your major complaint?_____
_____
_

What has changed to make you feel less like yourself?_____
_____
_____
__

What symptom do you hope we can most help you with?_____

_____

_____

__

HORMONE REPLACEMENT THERAPY PATIENT INFORMATION SHEET

Have you experienced any of the following symptoms recently? Please circle the number that best describes your experiences, with ***one*** being ***extremely mild*** and ***ten*** being ***extremely severe***.

Fatigue/Tiredness	1	2	3	4	5	6	7	8	9	10
Decrease Physical Stamina	1	2	3	4	5	6	7	8	9	10
Irritability/Anger/ Bad Temper	1	2	3	4	5	6	7	8	9	10
Erection/Potency Problems	1	2	3	4	5	6	7	8	9	10
Increased Fat Distribution In Chest Area or Hips	1	2	3	4	5	6	7	8	9	10
Increase in Waist Size- Weight Gain in Mid-Section	1	2	3	4	5	6	7	8	9	10
Decrease Muscle Mass	1	2	3	4	5	6	7	8	9	10
Increase in Aches, Joint And Muscle Pains	1	2	3	4	5	6	7	8	9	10
Feeling Burned Out-Loss Of Motivation	1	2	3	4	5	6	7	8	9	10
Dry Skin on Face/Hands	1	2	3	4	5	6	7	8	9	10
Loss of Early Morning Erection	1	2	3	4	5	6	7	8	9	10
Decreased Libido-Less Desire for Sex	1	2	3	4	5	6	7	8	9	10
Feeling of Depression- A Sense that Work, Marriage or Recreational Activities have lost Significance	1	2	3	4	5	6	7	8	9	10

When was your last PSA Test?_____

When was your last Prostate Exam?_____

What was your last Testosterone Level?_____

What was your last Estradiol Level?_____

Follow-Up Checklist

_____ Gift bag & Welcome Letter
_____ Thank You Card
_____ 3 Week phone call
_____ 3 Month phone call
_____ 1 Year Appointment Scheduled
_____ 1 Year Appointment

Consultation/Visit Notes