Custom Prescription Shoppe
1543 15th Street
Augusta, GA 30901
Phone: 706-737-3955
Fax: 706-737-6323

Custom Pharmacy
1202 Town Park Lane, Ste. 101
Evans, GA 30809
Phone: 706-760- 7956
Fax: 706-993-3772

Custom Pharmacy of NA
401 West Martintown Rd, Ste. 153
North Augusta, SC 29841
Phone: 803-693-5514
Fax: 803-792-9066

Medical History Form

Today's Date: _____

1. Patient Information

Patient Name: _____DOB:_____

Address: _____City: _____State:_____ Zip: _____

Phone: _____ Email: _____

2. Lifestyle information

	Do you use? Yes or no	If YES how often and how much
Tobacco (smoke, chew, dip, vape)		
Alcohol (beer, wine, 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:

Diet: Describe your typical daily food intake:

1st Meal 2nd Meal 3rd Meal Snacks

3. 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/location and phone number, if known

Name_____ Address_____ Phone_____

Name_____ Address_____ Phone_____

Name_____ Address_____ Phone_____

Patient signature:_____ Date:_____

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4. Allergies: Please check all that apply:

__ Penicillin __ Morphine __ Dye allergies __ Pet allergies
__ Codeine __ Aspirin __ Nitrate __ Seasonal (Pollen)
__ Sulfa drug __ Food allergies __ No known Other: _____

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

5. Over the counter (OTC) issues:

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

__ Pain reliever
__ Aspirin
__ Acetaminophen (Tylenol®)
__ Ibuprofen (Motrin®)
__ Naproxen (Aleve®)
__ Cough Suppressant (Ex: Robitussin®)
__ Antihistamine (Ex: Benadryl®, Zyrtec®)
__ Decongestant (Ex: Sudafed®)
__ Sleep Aid (Ex: Nyquil®)
__ Combination product (cough+cold, Robitussin DM®)
__ Antidiarrheal (Ex: Imodium®)
__ Laxatives (Ex: Colace®, Miralax®, Senokot®)
__ Diet Aid/Weight Loss Supplement
__ Antacids (Ex: Maalox®, Tums®)
__ Acid Blockers (Ex: Pepcid, Zantac, Prilosec, Nexium)
__ Other (Please list below)
_____
_____

__ Nutritional/Natural Supplements (Ex: Vitamins, Minerals, Herbs, Workout Supplements)

Supplement Name	Dose/Frequency

6. Medical Conditions. Please Check all that apply to you.

__ Heart Disease (Ex: Heart Failure)
__ High Cholesterol
__ High Blood Pressure
__ Cancer
__ Ulcers (GERD, Gastric)
__ Thyroid Disorders
__ Hormone Imbalances
__Blood Clotting Disorders
__ Eye Disorders (Ex: Glaucoma)
__ Lung Condition (Ex: Asthma, COPD, Emphysema)
__ Diabetes
__ Arthritis or other joint issues
__ Depression or other mood disorders
__ Epilepsy or other seizure disorders
__ Headaches/migraines
__ Other (Please list below)
_____
_____

7. Prescription Medications:

Medication Name	Dose/Frequency	Prescribing Physician

Patient signature:_____ Date:_____

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Male Hormone Screening

Have you experienced any of the following symptoms recently? Please circle the number that best describes your experiences, with **1 being rare** and **4 being Severe**.

	Rare	Mild	Frequent	Severe
1. Fatigue, tiredness or loss of energy	1	2	3	4
2. Decrease in physical stamina	1	2	3	4
3. Feelings of depression – a sense that work, marriage or recreational activities have lost significance	1	2	3	4
4. Decreased libido – less desire for sex	1	2	3	4
5. Erection or potency problems	1	2	3	4
6. Loss of early morning erection	1	2	3	4
7. Dry Skin on face or hands	1	2	3	4
8. Increase in waist size – weight gain especially around the mid-section	1	2	3	4
9. Increased fat distribution in chest area or hips	1	2	3	4
10. Feeling burned out, loss of motivation	1	2	3	4
11. Increase in aches, joint and muscle pains	1	2	3	4
12. Frequent use of alcohol, now or in the past	1	2	3	4
13. Increased irritability, anger or bad temper	1	2	3	4
14. Decrease in muscle mass	1	2	3	4
15. The age you are:_____ The age you feel: _____				

What prescription and/or non-prescription drugs are you taking (include vitamins, herbal products, or other supplements)? _____

_____

_____

What medical conditions are you being treated for? _____

_____

_____

What medical conditions have you been treated for in the past 5 years?_____

_____

_____

Patient signature:_____ Date:_____

Symptoms List

The following score sheet will help you to determine whether hormone testing is needed, and which tests to order. Each category is divided into hormone deficiency and excess, as each has a different subset of symptoms. Score the symptoms which apply to you as **O (none), 1 (mild), 2 (moderate), or 3 (severe).** A score of 10 or higher in any one category (deficiency and excess combined) is probably worthwhile to test.

Estrogen(Estradiol)

Estrogen Deficiency

___ Hot Flashes
___ Night sweats
___ Vaginal dryness
___ Foggy thinking
___ Memory lapses
___ Incontinence
___ Tearful
___ Depressed
___ Sleep disturbances
___ Heart palpitation
___ Bone loss

Estrogen Excess

___ Mood Swings (PMS)
___ Tender breasts
___ Water retention
___ Nervous
___ Irritable
___ Anxious
___ Fibrocystic breasts
___ Uterine fibroids
___ Weight gain in hips
___ Bleeding changes
___ Headaches

Progesterone

Progesterone Deficiency

___ Hot Flashes
___ Night sweats
___ Vaginal dryness
___ Foggy thinking
___ Memory lapses
___ Incontinence
___ Tearful
___ Depressed
___ Sleep Disturbances
___ Heart palpitation
___ Bone loss

Progesterone Excess

___ Sleepiness
___ Breast swelling/tenderness
___ Decreased libido
___ Mild depression
___ Candida infections

Androgens (DHEA and Testosterone)

Androgen Deficiency

___ Low libido
___ Vaginal dryness
___ Foggy thinking
___ Fatigue
___ Aches/pains
___ Memory !apes
___ Incontinence
___ Depressed
___ Sleep Disturbances
Bone loss
___ Decreased muscle mass
___ Thinning skin

Androgen Excess

___ Excessive facial/body hair
___ Loss of scalp hair
___ Increased acne
___ Oily skin

Cortisol

Cortisol Deficiency

___ Fatigue
___ Sugar craving
___ Allergies
___ Chemical sensitivity
___ Stress
___ Cold body temperature
___ Heart palpitations
___ Aches/pains
___ Arthritis

Cortisol Excess

___ Sleep disturbances
___ Bone loss
___ Fatigue
___ Weight gain in waist
___ Loss of muscle mass
___ Thinning skin

Patient signature:_____ Date:_____