Pacific Compounding Pharmacy and Consultations
Confidential Evaluation

General Information

Date:_____

Name: _____ Age:_____ Birth Date:_____

Full Address:_____

Home Ph:_____ Work Ph:_____Cell Ph:_____

Occupation:_____ Full time _____ Part Time _____ Retired _____ Unemployed ____ Other _____

Living Situation: Spouse _____ Alone _____ Partner _____ Friends _____ Parents _____ Children _____ Other _____

Who referred you to Pacific Compounding Pharmacy?_____

What are your goals for this consult?_____

_____

_____

Medical Status

General Health (circle): Excellent Good Fair Poor Weight: _____ Height: _____

Current diagnosis or medical conditions: _____

_____

List drug allergies:_____

List allergies to food, pollens, etc:_____

_____

_____

Past Medical Conditions

- ❑ Acne
- ❑ Arthritis
- ❑ Asthma
- ❑ Cancer
- ❑ Chronic Fatigue
- ❑ Clotting Defects
- ❑ Colitis
- ❑ Diabetes
- ❑ Eating Disorder
- ❑ Epilepsy
- ❑ Erectile Dysfunction
- ❑ Fibromyalgia
- ❑ Fractures
- ❑ Gallbladder Trouble
- ❑ Heart Trouble
- ❑ High Blood Pressure
- ❑ Kidney Trouble
- ❑ Liver Trouble
- ❑ Migraines
- ❑ Stroke
- ❑ Thyroid Trouble

Current Medications (name, dosage, and frequency of use):_____

_____

_____

_____

_____

_____

_____

Current Vitamins or Over The Counter products:_____

_____

_____

Current herbs or natural products: _____

_____

_____

Habits

Dietary restrictions and/or diet plan: _____

Do you get routine physical exercise? _____ What type? _____

How much? _____

Do you use tobacco products? _____ How much? ____ Previously? _____ How Long? ____

Do you use alcohol products? _____ How much? ____ Previously? _____ How Long? ____

Do you use caffeine products? _____ How much? _____

Stress Level: High _____ Moderate _____ Low _____

General causes of stress:_____

When was your cholesterol level checked?_____Results: _____

When was your last bone density scan?_____Results: _____

What is your blood pressure?_____

What time do you go to bed?_____ Wake up? _____Do you sleep well? _____

Family History

Please list family members that may have important diseases such as: High Blood Pressure, Heart Disease, Cancer, Diabetes, Osteoporosis, etc:_____

_____

_____

_____

Circle Yes or No to the following questions. If yes, indicate if Mild, Moderate or Severe.

1. Do you feel more fatigued and/or tired than usual? **Yes** **No**

   If yes, circle: **Mild** **Moderate** **Severe**

2. Have you noticed a decrease in your muscle mass? **Yes** **No**

   If yes, circle: **Mild** **Moderate** **Severe**

3. Have you experienced a loss in muscle strength? **Yes** **No**

   If yes, circle: **Mild** **Moderate** **Severe**

4. Have you experienced an increase in joint and/or muscle pains? **Yes** **No**

   If yes, circle: **Mild** **Moderate** **Severe**

5. Have you noticed an increase in your waist size? **Yes** **No**

   If yes, circle: **Mild** **Moderate** **Severe**

6. Do you have trouble losing weight? **Yes** **No**

   If yes, circle: **Mild** **Moderate** **Severe**

7. Have you experienced a loss in height? **Yes** **No**

   If yes, circle: **Mild** **Moderate** **Severe**

8. Do you have a decrease in your sex drive? **Yes** **No**

   If yes, circle: **Mild** **Moderate** **Severe**

9. Have you experienced difficulty in establishing and/or maintaining full erections? **Yes** **No**

   If yes, circle: **Mild** **Moderate** **Severe**

10. Do you have a decrease in spontaneous early morning erections? **Yes** **No**

    If yes, circle: **Mild** **Moderate** **Severe**

11. Have you experienced changes in your usual sleep pattern? **Yes** **No**

    If yes, circle: **Mild** **Moderate** **Severe**

12. Do you feel a decrease in your mental sharpness? **Yes** **No**

    If yes, circle: **Mild** **Moderate** **Severe**

13. Have you had trouble concentrating? **Yes** **No**

    If yes, circle: **Mild** **Moderate** **Severe**

14. Do you experience less enjoyment in personal interests and hobbies? **Yes** **No**

    If yes, circle: **Mild** **Moderate** **Severe**

Patient questions or concerns

Medical Information Release Form

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip code: _____ Phone: _____

Persons, Provides or Organizations

Name	Address	Telephone
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Pharmacy Record Release Authorization

I, the undersigned patient, authorize my pharmacist to release my personal medication and/or other medical information to the above listed persons or organizations upon request or as deemed necessary. I understand that employees of Pacific Compounding Pharmacy and Consultations will protect my privacy and this information will be released to other health care professionals only when it is necessary in order to provide health care services to me. This authority shall continue until revoked by me in writing.

Patient Signature: _____ Date: _____

Physician Medical Release Authorization

I hereby authorize the above listed physicians or organizations to furnish an agent of Pacific Compounding Pharmacy and Consultations any and all records pertaining to my medical history, services rendered and/or treatments. I understand that employees of Pacific Compounding Pharmacy and Consultations will protect my privacy and this information will be released to other health care professionals only when it is necessary in order to provide health care services to me. I further understand that a Green Brothers Pharmacy employee will not release this information unless authorized by me in writing as indicated above. This authority shall continue until revoked by me in writing.

Patient Signature: _____ Date: _____