Male Hormone Replacement
Confidential *Follow-Up* Evaluation

The answers provided in the questions below will allow the pharmacist to maintain your medical history and will help in advising you about current therapies for hormone replacement. All information will be kept confidential.

General Information

Today's Date: _____

Name: _____ Age:_____ Birth Date:_____

Medical Status

Overall satisfaction with HRT? Excellent ____ Good ____ Fair ____ Poor ____

General Health: Excellent ____ Good ____ Fair ____ Poor ____ Weight: _____ Height: _____

New diagnosis or medical conditions since last appointment: _____

_____

Medication History

Current Hormone Strength How you use it

_____

_____

_____

Medication Name Strength How often per day Date Started

_____

_____

_____

_____

Habits

Any changes in Diet/Meal Plan since last visit?_____

How often and how much?

Do you get physical exercise? Yes ❑ No ❑ _____

Do you use tobacco products? Yes ❑ No ❑ _____

Do you use alcohol products? Yes ❑ No ❑ _____

Do you use caffeine products? Yes ❑ No ❑ _____

Stress Level: High_____ Moderate _____ Low _____

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

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