



Patient signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History Form**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

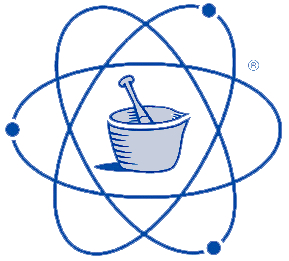
**1. Patient Information**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Page 1



**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

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 \_\_ Combination product (cough+cold, Robitussin DM®)

\_\_ Aspirin \_\_ Antidiarrheal (Ex: Imodium®)

\_\_ Acetaminophen (Tylenol®) \_\_ Laxatives (Ex: Colace®, Miralax®, Senokot®)

\_\_ Ibuprofen (Motrin®) \_\_ Diet Aid/Weight Loss Supplement

\_\_ Naproxen (Aleve®) \_\_ Antacids (Ex: Maalox®, Tums®)

\_\_ Cough Suppressant (Ex: Robitussin®) \_\_ Acid Blockers (Ex: Pepcid, Zantac, Prilosec, Nexium)

\_\_ Antihistamine (Ex: Benadryl®, Zyrtec®) \_\_ Other (Please list below)

\_\_ Decongestant (Ex: Sudafed®) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Sleep Aid (Ex: Nyquil®) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ 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) \_\_ Lung Condition (Ex: Asthma, COPD, Emphysema)

\_\_ High Cholesterol \_\_ Diabetes

\_\_ High Blood Pressure \_\_ Arthritis or other joint issues

\_\_ Cancer \_\_ Depression or other mood disorders

\_\_ Ulcers (GERD, Gastric) \_\_ Epilepsy or other seizure disorders

\_\_ Thyroid Disorders \_\_ Headaches/migraines

\_\_ Hormone Imbalances \_\_ Other (Please list below)

\_\_Blood Clotting Disorders \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

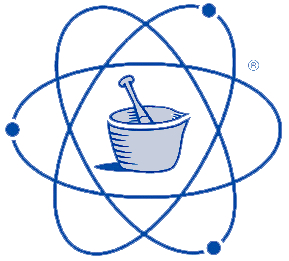
\_\_ Eye Disorders (Ex: Glaucoma) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Prescription Medications:

|  |  |  |
| --- | --- | --- |
| Medication Name | Dose/Frequency | Prescribing Physician |
|  |  |  |
|  |  |  |
|  |  |  |

Patient signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Page 2



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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, 1 2 3 4

marriage or recreational activities have lost significance

1. Decreased libido – less desire for sex 1 2 3 4
2. Erection or potency problems 1 2 3 4
3. Loss of early morning erection 1 2 3 4
4. Dry Skin on face or hands 1 2 3 4
5. Increase in waist size – weight gain especially 1 2 3 4

around the mid-section

1. Increased fat distribution in chest area or hips 1 2 3 4
2. Feeling burned out, loss of motivation 1 2 3 4
3. Increase in aches, joint and muscle pains 1 2 3 4
4. Frequent use of alcohol, now or in the past 1 2 3 4
5. Increased irritability, anger or bad temper 1 2 3 4
6. Decrease in muscle mass 1 2 3 4
7. 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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Page 3

Patient signature: Date:

|  |
| --- |
| **Estrogen**(Estradiol)  **Estrogen Deficiency** **Estrogen Excess**  Hot Flashes Mood Swings (PMS)  Night sweats \_ Tender breasts  Vaginal dryness Water retention  Foggy thinking Nervous  Memory lapses Irritable  Incontinence Anxious  Tearful Fibrocystic breasts  Depressed Uterine fibroids  Sleep disturbances Weight gain in hips  Heart palpitation Bleeding changes  Bone loss Headaches |
| **Progesterone**  **Progesterone Deficiency** Heart palpitation  Hot Flashes Bone loss  Night sweats  Vaginal dryness  Foggy thinking **Progesterone Excess**  Memory lapses Sleepiness  Incontinence Breast swelling/tenderness  Tearful Decreased libido  Depressed Mild depression  Sleep Disturbances Candida infections |
| **Androgens (DHEA and Testosterone**)  **Androgen Deficiency** Bone loss  Low libido Decreased muscle mass  Vaginal dryness Thinning skin  Foggy thinking  Fatigue **Androgen Excess**  Aches/pains Excessive facial/body hair  Memory !apes Loss of scalp hair  Incontinence Increased acne  Depressed Oily skin  Sleep Disturbances |
| **Cortisol**  **Cortisol Deficiency** Arthritis  Fatigue  Sugar craving **Cortisol Excess**  Allergies Sleep disturbances  Chemical sensitivity Bone loss  Stress Fatigue  Cold body temperature Weight gain in waist  Heart palpitations Loss of muscle mass  Aches/pains Thinning skin |

Page 5

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**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.