South River Compounding Pharmacy & Wellness Center

2300 Robious Station Circle
Midlothian, VA 23113
Fax: 804-897-6449
(804) 897-6447
www.southriverRx.com

3656 Mayland C
Richmond, VA 23233
Fax: 804-967-64
Toll Free: 1-888-879-7713
info@southriverRx.co

Brief Evaluation - Male

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

GENERAL INFORMATION

Date:_____

Name:_____Age:_____Birth Date:_____
Address:_____
Home Phone:_____Work Phone:_____
E-Mail:_____Current Health Care Provider_____
What are your health goals?:_____
_____

PRESCRIPTION INSURANCE

Carrier:_____ ID#:_____
Group#:_____ Relationship to Cardholder:_____
Cardholder Name:_____ Employer:_____

Have you had the following labs drawn recently, if so please list the levels:

Progesterone:_____
Total Estrogen:_____
Testosterone:_____
Sex Hormone Binding Globulin:_____
Thyroid:_____
DHEA:_____

MEDICAL STATUS

General Health- Excellent:____Good:____Fair:____Poor:____ Current Weight:_____Ideal Weight:_____
Current diagnosis or medical conditions:_____
_____
Current Medications:_____
_____
Current Vitamins or OTC products:_____

SYMPTOMS

Rate your current status for each symptom by checking the appropriate modifier. Please feel free to use additional space to describe any symptom. This section may be repeated upon subsequent visits.

	ABSENT	MILD	MODERATE	SEVERE
Water retention, edema				
Frequently ill				
Anxiety				
Irritability				
Depression				
Headaches				
Difficulty losing gain				
Craving for sweets				
Difficulty Falling Asleep				
Difficulty Staying Asleep				

- ☐ Have unusual fatigue unrelated to exertions?
- ☐ Feel chillier than others, often needing to wear socks to bed?
- ☐ Dress in layers because of needing to adjust to various temperatures?
- ☐ Have feelings of anxiety that sometimes lead to panic?
- ☐ Have trouble with weight, often eating lightly, yet still not losing a pound?
- ☐ Experience aches/pains in muscles/joints unrelated to trauma or exercise?
- ☐ Have increased problems with digestion or allergies?
- ☐ Feel mentally sluggish, unfocused, or unusually forgetful?
- ☐ Know of anyone in your family who has ever had a thyroid problem?
- ☐ Suffer from dry skin, or are prone to adult acne or eczema?
- ☐ Go through periods of depression, and/or lowered sex drive?
- ☐ Family history of diabetes, anemia, rheumatoid arthritis, early graying hair?
- ☐ Experience your hair as feeling like straw, dry and easily falling out?
- ☐ Have significant menopausal symptoms or migraine despite estrogen?
- ☐ Have a history of whiplash or other neck injuries?
- ☐ Have a history of significant exposure to chlorine, bromine, or fluoride?
- ☐ Feel utterly exhausted by evening, yet have trouble sleeping?\
- ☐ Do you wake up tired?

Androgen Deficiency Section

Please put an X in the appropriate box (Yes, No or Don't Know):	Yes	No	Don't Know
Have you ever been diagnosed with low testosterone?			
IF YES, are you being treated for it?			
IF NO:			
Do you have a decreased libido (sex drive)?			
Do you have a lack of energy?			
Do you have a decrease in strength or endurance?			
Have you lost height?			
Have you noticed a decreased "enjoyment of life"?			
Are you sad and/or grumpy?			
Are your erections less strong?			
Have you noticed a recent deterioration in your ability to play sports?			
Are you falling asleep after dinner?			
Has there been a recent deterioration in your work performance?			

SYMPTOMS III

Rate your current status for each symptom by checking the appropriate modifier. Please feel free to use additional space to describe any symptom. This section may be repeated upon subsequent visits.

	ABSENT	MILD	MODERATE	SEVERE
Energy crashes mid-afternoon				
Fatigue, lack of energy				
Craving salty food				
Exhausted easily				
Sensitive to changes in weather				
Loss of sex drive				
Dark circles under eyes				
Wounds heal slowly				
Body tender/sensitive to touch				
Feel puffy/swollen all over				
Does your mind race at bedtime				

Date:_____ Signature:_____

Since health information may change periodically, please notify your South River Compounding pharmacist of any new medications (prescription and nonprescription), allergies, drug reactions or health conditions.

Your signature acknowledges your receipt of SRCP's Notice of Privacy Practices according to New Federal Government HIPAA Regulations (This notice describes how medical information about you may be used and disclosed). It does not acknowledge your agreement or any restrictions you may request regarding your Protected Health Information.

12/2011br