



Stanley Pharmacy Compounding Center
2413 West Beebe-Capps Expressway
Searcy, Arkansas 72143

Tel. (501) 305-4108

Fax (501) 305-4514

CONFIDENTIAL HORMONE EVALUATION--MALE

I understand that the fee for this consultation is \$60.00. _____(initials)

I understand that insurance does not always cover compounded hormone replacement prescriptions, but Stanley Pharmacy will provide claim forms to turn in to request reimbursement. _____(initials)

I acknowledge my understanding of the Health Insurance Portability and Accountability Act (HIPAA) and that I have been offered a copy of Stanley Pharmacy's Notice of Privacy Practices.

Signature _____ Initials _____

Who referred you to Stanley Pharmacy for hormone replacement?

Today's Date: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Best Number to reach you _____

Place of Employment _____ Height: _____ Weight: _____

Email Address _____

Insurance Information

Insurance Name: _____

Subscriber I. D. #: _____ Group #: _____

Cardholder Name: _____ Cardholder Birthdate _____

Doctor's Name

Address

Phone

Allergies: Please check all that apply.

penicillin morphine dye allergies pet allergies
 codeine aspirin nitrate allergy seasonal (pollen) allergies
 sulfa drugs food allergies no known allergies other: _____

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

How often & how much?

Do you use tobacco?	Yes/No	_____
Do you use alcohol?	Yes/No	_____
Do you use caffeine?	Yes/No	_____

Please list any OTC (Over-the-Counter) products that you use occasionally or regularly.
(i.e. pain relievers, sleep aids, vitamins, antacids, allergy medications, laxatives, or herbal supplements)

Please list all current medical conditions/diseases.
(i.e. high blood pressure, high cholesterol, diabetes, thyroid disease, migraines, depression, arthritis, asthma)

Current Prescription Medications:

Medication Name	Strength	Date Started	How often per day
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List Hormones previously taken	Date started	Date stopped	Reason
_____	_____	_____	_____

What is your major complaint? _____

What has changed to make you feel less like yourself? _____

What symptom do you hope we can most help you with? _____

HORMONE REPLACEMENT THERAPY PATIENT INFORMATION SHEET

Have you experienced any of the following symptoms recently? Please circle the number that best describes your experiences, with **one** being **extremely mild** and **ten** being **extremely severe**.

Fatigue/Tiredness	1	2	3	4	5	6	7	8	9	10
Decrease Physical Stamina	1	2	3	4	5	6	7	8	9	10
Irritability/Anger/ Bad Temper	1	2	3	4	5	6	7	8	9	10
Erection/Potency Problems	1	2	3	4	5	6	7	8	9	10
Increased Fat Distribution In Chest Area or Hips	1	2	3	4	5	6	7	8	9	10
Increase in Waist Size- Weight Gain in Mid-Section	1	2	3	4	5	6	7	8	9	10
Decrease Muscle Mass	1	2	3	4	5	6	7	8	9	10
Increase in Aches, Joint And Muscle Pains	1	2	3	4	5	6	7	8	9	10
Feeling Burned Out-Loss Of Motivation	1	2	3	4	5	6	7	8	9	10
Dry Skin on Face/Hands	1	2	3	4	5	6	7	8	9	10
Loss of Early Morning Erection	1	2	3	4	5	6	7	8	9	10
Decreased Libido-Less Desire for Sex	1	2	3	4	5	6	7	8	9	10
Feeling of Depression- A Sense that Work, Marriage or Recreational Activities have lost Significance	1	2	3	4	5	6	7	8	9	10

When was your last PSA Test? _____

When was your last Prostate Exam? _____

What was your last Testosterone Level? _____

