

# Confidential Male Hormone Evaluation Form

This document can be printed.

Please fill out the information completely, then fax or send to:

Hazle Drugs

Attn: Bill Spear, R.Ph., CCN

1 E. Broad Street

Hazleton, PA 18201

Fax: 570-454-4532 or 800-400-8764

Our Andropause Hormonal Specialist will then contact you to schedule your hormonal consultation either in person or by phone.

**Date:**

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Rate the following as they apply to you - Use the numbers 1-4, with 1 being Rare or Mild, and 4 being Frequent or 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, marriage, and/or recreational activities have lost significance	1	2	3	4
4) Decreased libido - less desire for sex	1	2	3	4
5) Erection or potency problems	1	2	3	4
6) Loss of early morning erection	1	2	3	4
7) Dry Skin on face or hand	1	2	3	4
8) Increased waist size – weight gain, especially Around mid section	1	2	3	4
9) Increased fat distribution in chest area or hips	1	2	3	4
10) Feeling burned out, loss of motivation	1	2	3	4

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|--|---|---|---|---|
| 11) Increase in aches, joint and muscle pains      | 1 | 2 | 3 | 4 |
| 12) Frequent use of alcohol - now or in the past   | 1 | 2 | 3 | 4 |
| 13) Increased irritability, anger, or bad temper   | 1 | 2 | 3 | 4 |
| 14) Decrease in muscle mass                        | 1 | 2 | 3 | 4 |
| 15) The age you are; _____ The age you feel: _____ |   |   |   |   |

Do you experience any of the following?	<u>Yes</u>	<u>No</u>	<u>Sometimes</u>
1. indigestion, gas heartburn, cramping	_____	_____	_____
2. poor appetite, nausea, heartburn	_____	_____	_____
3. constipation or diarrhea	_____	_____	_____
4. diet changes for bowel integrity	_____	_____	_____
5. crave sweets	_____	_____	_____
6. allergies – food or environmental	_____	_____	_____
7. muscle/joint cramping or soreness	_____	_____	_____
8. eyes sensitive to bright light, stress	_____	_____	_____
9. flashes, sparks or floaters in eyes	_____	_____	_____
10. headaches	_____	_____	_____
11. poor circulation, hands, feet	_____	_____	_____
12. toxic metal exposure - work/living	_____	_____	_____
13. emotional stress, anxiety, depression	_____	_____	_____
14. parasitic or bacterial infections	_____	_____	_____
15. special or vegetarian diet	_____	_____	_____
16. fatigue	_____	_____	_____

Have you ever been treated for Prostate Cancer? \_\_\_\_\_ Yes \_\_\_\_\_ No

Did any medical professional ever suggest that you may have symptoms of prostate enlargement? \_\_\_\_\_ Yes \_\_\_\_\_ No

Please list any prescription medication that you are currently taking:

Please list any non-prescription drugs that you are taking (including vitamins, herbal products, or other supplements):

Please list any medical conditions in which you are receiving treatment

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Please list any medical conditions have you been treated for in the past 5 years: