

Confidential Male Hormone Evaluation Form

This document can be printed.

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

Hazle Compounding

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
- 2) Decrease in physical stamina
- 3) Feelings of depression - a sense that work, marriage, and/or recreational activities have lost significance
- 4) Decreased libido - less desire for sex
- 5) Erection or potency problems
- 6) Loss of early morning erection
- 7) Dry Skin on face or hand
- 8) Increased waist size – weight gain, especially around mid section
- 9) Increased fat distribution in chest area or hips
- 10) Feeling burned out, loss of motivation
- 11) Increase in aches, joint and muscle pains
- 12) Frequent use of alcohol - now or in the past
- 13) Increased irritability, anger, or bad temper

14) Decrease in muscle mass

15) The age you are; _____ The age you feel: _____

Do you experience any of the following?

Yes No Sometimes

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:

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