Boudreaux's
NEW DRUG STORE
The Problem Solvers

COMPOUNDING SPECIALISTS:
♦ CLINT DANIEL, R.PH. ♦ STACY TEER, PHARM D.

404 East Prien Lake Rd.
Lake Charles, La. 70601

Phone: (337) 436-7216

Fax: (337) 436-7217

Email: newdrug@bellsouth.net

MALE HORMONE SCREENING
CONFIDENTIAL EVALUATION

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

Confidential Medical History Form

Please return your forms to Boudreaux's New Drug Store when you have completed them. The Pharmacist will schedule a consultation to meet with you to further discuss your information.

Today's Date:____________

Name:___________________________ Birth date:_______________ Age:________

Address:____

City:_______________________________ State:___________________ Zip:_____________

Home Phone:________________________ Work Phone:______________________________

Cell Phone:__________________________ Email address:___________________________

Occupation:_________________________ Full-time:______ Part-time:______ Retired:_____

Status: Married:_____ Single:_____ Divorced:_____ Widowed:_____

Living Situation: Spouse____ Alone____ Children ____ Partner____ Parents ____ Other ____

Pets:____

Goals of Hormone Evaluation:____

Current Medical Status:

General Health**:** Excellent:____Good:____Fair:____Poor:____Height:______Weight: _______

Do you use tobacco? Yes – No If yes, how much and how often? _______________________

Do you use alcohol? Yes – No If yes, how much and how often? _______________________

Do you use caffeine? Yes – No If yes, how much and how often? _______________________

Primary Physician: ____

Additional Clinicians: ____

Allergies:

Please list any allergies that you have and the reaction you experienced:

____

____

____

____

____

Dietary Habits and Exercise:

Dietary Restrictions:____

Meal Choices :(Be as specific as you can)

Breakfast:____

Lunch:____

Dinner:____

Do you get routine exercise?_____ What type(s)?___________________________________

How often?___________________ Do you belong to a fitness club?______________________

Medical Conditions/Diseases: **Please check all that apply to you.**

_____Heart Disease	_____High Cholesterol	_____High Blood Pressure
_____Cancer	_____Ulcers	_____Thyroid Disease
_____Lung Condition	_____Arthritis	_____Diabetes
_____Arthritis	_____Osteoporosis	_____Depression
_____Headaches/Migraines	_____Eye Disease	_____Other

Current Prescription Medications:

Medication Name	Strength	Date Started	Times Per Day

1)____
2)____
3)____
4)____
5)____
6)____
7)____
8)____

List medications previously taken:

Medication Name	Date Started	Date Stopped	Reason for Stopping

____
____
____
____

Vitamins/Nutritional Supplements/Herbals/etc:

____
____
____
____

Over the counter(OTC) products used:

Please list all products that you use regularly including how much you take a day.

____
____
____

Medical History:

Please indicate the most recent results of the following test(s) that you have had done.

Prostate Exam_____________ Date: ___________________ Results:___________

PSA Level_________________ Date: ___________________ Results:___________

Cholesterol_________________ Date: ___________________ Results:___________

Have you ever had an abnormal prostate exam?__________ Treatment____________________

Do you have a family history of any of the following?

Prostate cancer____________ Family Member(s)________________________________
Testicular Cancer___________ Family Member(s)________________________________
Breast Cancer____________ Family Member(s)________________________________
Heart Disease____________ Family Member(s)________________________________
Osteoporosis____________ Family Member(s)________________________________
High Blood Pressure______ Family Member(s)________________________________
High Cholesterol________ Family Member(s)________________________________
Depression____________ Family Member(s)________________________________
Diabetes______________ Family Member(s)________________________________
Thyroid Disease________ Family Member(s)________________________________

Please circle the number that best describes your experiences with the following symptoms.

	Rare	**Mild**	**Frequent**	**Severe**
Sleep Disruptions	1	2	3	4
Fatigue, Tiredness, or Loss of Energy	1	2	3	4
Decrease in Strength	1	2	3	4
Decrease in Physical Stamina	1	2	3	4
Loss of Height	1	2	3	4
Decreased Enjoyment of Life	1	2	3	4
Feelings of Depression	1	2	3	4
Decreased Work Performance	1	2	3	4
Decreased Libido-Less Desire for Sex	1	2	3	4
Erections Less Strong	1	2	3	4
Loss of Early Morning Erection	1	2	3	4
Dry Skin on Face and Hands	1	2	3	4
Hair Loss; Face, Body, Groin	1	2	3	4
Increase in Waist Size-Weight Gain	1	2	3	4
Fat Distribution on Chest or Hips	1	2	3	4
Feeling Burned Out/Decreased Motivation	1	2	3	4
Increase in Aches, Joint and Muscle Pain	1	2	3	4

Frequent use of Alcohol-Now or in the Past	1	2	3	4
Increased Irritability, Anger or Bad Temper	1	2	3	4
Decrease in Muscle Mass	1	2	3	4
Do You Fall Asleep After Dinner	1	2	3	4
Lost Significance in Work/Marriage/Activities	1	2	3	4
Anxiety	1	2	3	4
Fuzzy Thinking	1	2	3	4
Food Cravings	1	2	3	4
Headaches	1	2	3	4
Memory Loss	1	2	3	4
Frequent Urination/Retention	1	2	3	4

Pharmacy Record Release Authorization Form

I, the undersigned patient, authorize my pharmacist to release my personal medication and/or other medical information to other clinicians/practitioners upon request or as deemed necessary.

I understand that employees of **Boudreaux's New Drug Store** will protect my privacy and that this information will be released to other health care professionals only when it is necessary in order to provide health care services to me.

This authority shall continue until revoked by me in writing.

Patient Name:____

Address:____

City/State/Zip:____

Phone:____

Signature:____

Date:____

Doctor Medical Release Authorization

I hereby authorize my physician to furnish Boudreaux's New Drug Store with any and all records pertaining to my medical history, services rendered and/or treatments that I have received. I understand that the employees of Boudreaux's New Drug Store will protect my privacy and that this information will be released to other health care professionals only when it is necessary in order to provide health care services to me. I further understand that a Boudreaux's New Drug Store employee will not release this information unless authorized by me, in writing. This authority shall continue in effect until revoked by me, in writing.

Physician Name:____

Address:____

City/State/Zip:____

Phone:____

Patient Name:______________________________Date of Birth____/____/____

Address:____

City/State/Zip:____

Phone:____

Signature:__________________________________ Date:________________