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	◯	◯	◯	◯
I1) 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: