PHARMACY COMPOUNDING SOLUTIONS
(MALE PACKET)

LYNN IRWIN SALLANDER - COMPOUNDING PHARMACIST
2310 MILDRED STREET WEST SUITE 138
UNIVERSITY PLACE, WA 98466
253.564.2323 PH / 253.564-3131 FAX

PATIENT INFORMATION AND HEALTH SUMMARY

Please complete the following confidential information and return to Pharmacy Compounding Solutions

Name _____/_____/_____
Last First M.I.

Address_____/_____/_____/_____
Street City State Zip Code

Phone (____)_____Sex ☐Male ☐ Female WA Drivers License:_____

Date of Birth ____/____/_____ E-mail Address _____

Person responsible for the account _____ Social Security Number_____

Employer_____ Phone (____)_____ Job Title _____

Business Address _____ City _____ State _____ Zip _____

Person to contact in the event of an emergency _____

Relationship _____ Telephone (____)_____

Who referred you to us? _____

AUTHORIZATION FOR TREATMENT

I, the undersigned, hereby authorize the physician/pharmacist to perform diagnostic tests deemed necessary for my care and to perform any and all forms of treatment, medication, and therapy that are indicated and are in accordance with the Standards of Care. I furthermore agree to use Pharmacy Compounding Solutions for all compounded prescriptions I choose to fill that the compounding pharmacist at PCS has consulted with me on. Failure to use Pharmacy Compounding Solutions will result in a consultation fee of $150.00 per consult. Furthermore, I understand that Pharmacy Compounding Solutions does not accept insurance. Payment is due at the time of appointment or pick up of medications. I understand I am responsible for billing my insurance company.

PATIENT SIGNATURE_____ DATE____/____/____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much and how often? _____
Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? _____
Do you exercise? ☐ Yes ☐ No If yes, what type and how often? _____
Do you consume caffeine? ☐ Yes ☐ No If yes, what type and how often? _____
Please describe your diet: _____

_____

Do you want child-resistant tops on your prescription containers? ☐ Yes ☐ No

MEDICAL HISTORY

Your Past/Current Medical Conditions	Family Members Past/Current Medical Conditions
☐ Alcoholism	☐ Alcoholism: Who? _____
☐ Alzheimer's	☐ Alzheimer's: Who? _____
☐ Anemia	☐ Anemia: Who? _____
☐ Arthritis (Type:_____)	☐ Arthritis (Type:_____)Who?_____
☐ Benign Prostatic Hyperplasia	☐ Benign Prostatic Hyperplasia: Who? _____
☐ Blood Clots (Type:_____)	☐ Blood Clots: (Type:_____) Who?_____
☐ Blood Disorders (Type:_____)	☐ Blood Disorders (Type:_____) Who?_____
☐ Cancer (Type:_____)	☐ Cancer (Type:_____) Who? _____
☐ Chronic Fatigue Syndrome	☐ Chronic Fatigue Syndrome: _____
☐ Clotting Disorder	☐ Clotting Disorder: Who? _____
☐ Depression	☐ Depression: _____
☐ Diabetes (Type:_____)	☐ Diabetes: (Type:_____) Who?_____
☐ Drug Addiction	☐ Drug Addiction: Who? _____
☐ Eating Disorder	☐ Eating Disorder: Who? _____
☐ Eczema	☐ Eczema: Who? _____
☐ Erectile Dysfunction	☐ Erectile Dysfunction: Who? _____
☐ Epilepsy	☐ Epilepsy: Who? _____
☐ Fibromyalgia	☐ Fibromyalgia: Who? _____
☐ Fractures	☐ Fractures: Who? _____
☐ Gallbladder Disease	☐ Gallbladder Disease: Who _____
☐ Gout	☐ Gout: Who? _____
☐ Headaches/Migraines	☐ Headaches/Migraines: Who? _____
☐ Heart Disease (Type:_____)	☐ Heart Disease: (Type:_____) Who?_____
☐ Hepatitis (Type: _____)	☐ Hepatitis (Type:_____) Who?_____
☐ High Blood Pressure	☐ High Blood Pressure: Who? _____
☐ High Cholesterol	☐ High Cholesterol: Who? _____
☐ HIV+	☐ HIV+: Who? _____
☐ Insomnia	☐ Insomnia: Who? _____
☐ Kidney Disorder	☐ Kidney Disorder: Who? _____
☐ Liver Disorder (Type: _____)	☐ Liver Disorder: Who? _____
☐ Lung Disorder (Type:_____)	☐ Lung Disorder: (Type:_____)Who?_____
☐ Mental Illness (Type: _____)	☐ Mental Illness: (Type:_____)Who?_____
☐ Migraines	☐ Migraines: Who? _____
☐ Osteoporosis	☐ Osteoporosis: Who? _____
☐ Psoriasis	☐ Psoriasis: Who? _____
☐ Seizures (Type:_____)	☐ Seizures (Type: _____)Who?_____
☐ Stroke	☐ Stroke: Who? _____
☐ Suicidal Thoughts or Attempts	☐ Suicidal Thoughts or Attempts: Who? _____
☐ Thyroid Disorder	☐ Thyroid Disorder: Who? _____
☐ Other:_____ _____	☐ Other Conditions(Type:_____) Who?_____

Are you currently on any prescription or non-prescription medication/supplements? ☐ Yes ☐ No

If yes, please list the medication and/or supplements on the lines below:

Medication/Supplement Strength Directions for use Reason for use Date Started

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

List any medications or supplements which you are allergic to and describe the reaction.

1. _____
2. _____
3. _____
4. _____
5. _____

Please list any food or other allergies you have: _____

_____

Are you chemically and/or environmentally sensitive? ☐ Yes ☐ No

Have you ever taken hormones (synthetic or natural) before? ☐ Yes ☐ No

If yes, please list the hormone medication(s) you have used on the lines below:

	Drug Name	Strength	When Used	Side Effects	Benefits
1					
2					
3					
4					
5					

If you discontinued the use of hormones, please briefly explain why. Additionally, please explain why you are seeking bio-identical hormone replacement therapy (HRT).

_____

_____

Have you tried any alternative therapies or taken any herbal or homeopathic products?

☐ Yes ☐ No If yes, please list them here: _____

_____

Circle Yes or No to the following questions. If yes, Indicate if Mild, Moderate or Severe.

		Yes	No
1.	Do you feel more fatigued and/or tired than usual?	☐	☐
	If yes, Mild **Mild Moderate Severe**		
2.	Have you noticed a decrease in your muscle mass?	☐	☐
	If yes, Mild **Mild Moderate Severe**		
3.	Have you experienced a loss in muscle strength?	☐	☐
	If yes, Mild **Mild Moderate Severe**		
4.	Have you experienced an increase in joint and/or muscle pains?	☐	☐
	If yes, Mild **Mild Moderate Severe**		
5.	Have you noticed an increase in your waist size?	☐	☐
	If yes, Mild **Mild Moderate Severe**		
6.	Do you have trouble losing weight?	☐	☐
	If yes, Mild **Mild Moderate Severe**		
7.	Have you experienced a loss in height?	☐	☐
	If yes, Mild **Mild Moderate Severe**		
8.	Do you have a decrease in your sex drive?	☐	☐
	If yes, Mild **Mild Moderate Severe**		
9.	Have you experienced difficulty in establishing and/or maintaining full erections?	☐	☐
	If yes, Mild **Mild Moderate Severe**		
10.	Do you have a decrease in spontaneous early morning erections?	☐	☐
	If yes, Mild **Mild Moderate Severe**		
11.	Have you experienced changes in your usual sleep pattern?	☐	☐
	If yes, Mild **Mild Moderate Severe**		
12.	Do you feel a decrease in your mental sharpness?	☐	☐
	If yes, Mild **Mild Moderate Severe**		
13.	Have you had trouble concentrating?	☐	☐
	If yes, Mild **Mild Moderate Severe**		
14.	Do you experience less enjoyment in personal interests and hobbies?	☐	☐
	If yes, Mild **Mild Moderate Severe**		
15.	Do you get angry easily?	☐	☐
	If yes, Mild **Mild Moderate Severe**		
16.	Do you get irritable or angry?	☐	☐
	If yes, Mild **Mild Moderate Severe**		
17.	Do you have breast enlargement?	☐	☐
	If yes, Mild **Mild Moderate Severe**		
18.	Do you have excessive sweating during the day or night?	☐	☐
	If yes, Mild **Mild Moderate Severe**		
19.	Do you lack interest in leisure or social activities?	☐	☐
	If yes, Mild **Mild Moderate Severe**		
20.	Do you have low stamina?	☐	☐
	If yes, Mild **Mild Moderate Severe**		

21. Do you have to urinate frequently? ☐ ☐
    If yes, Mild **Mild Moderate Severe**
22. When you urinate, do you have a weak urine stream? ☐ ☐
    If yes, Mild **Mild Moderate Severe**
23. When you urinate, is the flow slow to start? ☐ ☐
    If yes, Mild **Mild Moderate Severe**
24. Do you have trouble voiding your bladder completely? ☐ ☐
    If yes, Mild **Mild Moderate Severe**
25. Does your urine flow dribble at the end? ☐ ☐
    If yes, Mild **Mild Moderate Severe**
26. Do you have blood in your urine? ☐ ☐
    If yes, Mild **Mild Moderate Severe**
27. Do you experience urinary incontinence? ☐ ☐
    If yes, Mild **Mild Moderate Severe**
28. Do you have pain with urination? ☐ ☐
    If yes, Mild **Mild Moderate Severe**
29. Do you have pain with ejaculation? ☐ ☐
    If yes, Mild **Mild Moderate Severe**
30. Do you ever experience bloody ejaculation? ☐ ☐
    If yes, Mild **Mild Moderate Severe**
31. Do you ever have pain with intercourse? ☐ ☐
    If yes, Mild **Mild Moderate Severe**

Date of last prostate exam:_____

Date of last PSA test:_____Result:_____

Height _____ Weight _____ BMI (wt in kg/ht in meters sq) _____
(Pharmacist will calculate)

Waist Circumference_____ Hip Circumference_____ Waist/Hip Ratio_____
(Pharmacist will calculate)

BMI (BODY MASS INDEX)

Severely underweight	BMI 16 or less
Underweight	BMI 16 to 19
Ideal	BMI 19 to 24
Moderately overweight	BMI 24 to 26
Overweight	BMI 26 to 30
Moderately obese	BMI 30 to 33
Obese	BMI 33 to 40

WAIST TO HIP RATIO

A waist circumference greater than or equal to 40 increases the risk for men to develop metabolic complications.

BMI and waist circumference are very important to the patient's general health. However, new evidence suggests waist to hip ration is more consistently a predictor of metabolic complications.

General waist to hip ratio guidelines:

AGE	LOW RISK*	MODERATE RISK*	HIGH RISK*	VERY HIGH RISK*
20-29	< 0.8	0.8-0.9	0.9-0.94	> 0.95
30-39	< 0.85	0.85-0.9	0.9-0.95	> 0.96
40-49	< 0.87	0.87-0.93	0.93-1.0	> 1.0
50-59	< 0.9	0.9-0.95	0.95-1.0	> 1.0
60-69	< 0.9	0.9-0.97	0.97-1.1	>1.1

*RISK OF DEVELOPING METABOLIC COMPLICATIONS

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PATIENT NAME:_____

DOB:_____

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PHARMACIST ASSESSMENT AND PLAN

PHARMACIST SIGNATURE:_____DATE:_____

PROVIDER SIGNATURE AND APPROVAL:_____

Comments:_____

Please fax this page back with signature to approve the pharmacist's recommendation

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Release Authorization

_____I hereby release my Physician to furnish an agent of Pharmacy Compounding Solutions any and all records pertaining to my medical history, services rendered, and/or treatments.

_____I authorize my Pharmacist to release my personal medication and/or other medical information to my Physician(s) upon request or as deemed necessary.

_____I understand that employees of Pharmacy Compounding Solutions will protect my privacy and this information will be released to other healthcare professionals only when necessary in order to provide health care services to me. This authority shall continue until revoked by me in writing.

Physician Name:_____ Date of last visit _____
Physician Name:_____ Date of last visit _____
Physician Name:_____ Date of last visit _____

Patient Name:_____
Address:_____
City, State, Zip:_____
Phone:_____

Signature_____ Date:_____