RILEY'S DRUGS & VITAL CARE
SINCE 1924
Serving the community for good health

1207 West Main Street • Lexington, SC 29072
Phone 803.359.2587 • Fax 803.359.2588
www.rileysdrugs.com • rileys@rileysdrugs.com

Riley's Drugs Confidential Male Hormone Evaluation Follow-Up

Name: _____ Birth date: _____ Age: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Email Address: _____
Cell Phone: _____ Height: _____ Weight: _____
Primary Care MD: _____ Other Doctor:_____
Address: _____ Address: _____
Phone Number: _____ Phone Number: _____
Fax Number: _____ Fax Number: _____

At this point in the program my primary goals and/or chief concerns are:

_____
_____
_____
_____

I complied with the plan designed for me at the last visit and take my supplements and prescriptions as scheduled: □ Everyday □ 75% of the time □ 50% of the time □ 25% of the time □ Rarely
List any challenges/obstacles:_____
_____
_____

Over-the-counter (OTC): Please list the products you use occasionally or regularly including pain relievers, sleep aids, antacids, antihistamines, cold medicine, laxatives/stool softeners, diet aids, ect.

_____
_____
_____
_____

Nutritional/Natural Supplements: Please list the products you are using, including vitamins, minerals, herbs, enzymes and nutrition/protein supplements.

_____
_____
_____

Current Prescription Medications: Strength Date Started How often per day.

_____
_____
_____
_____
_____
_____

Patient Name: _____ Today's Date:_____

Symptoms:

List any new symptoms:_____

_____

_____

_____

Rate each symptom by checking the appropriate modifier. This section is repeated upon subsequent visits to monitor progress.

	Absent	Mild	Moderate	Severe	Comments:
Water retention/edema	□	□	□	□	_____
Frequently ill	□	□	□	□	_____
Anxiety	□	□	□	□	_____
Irritability	□	□	□	□	_____
Depression	□	□	□	□	_____
Headaches	□	□	□	□	_____
Difficulty losing/gaining weight	□	□	□	□	_____
Craving for Sweets	□	□	□	□	_____
Difficulty falling asleep	□	□	□	□	_____
Difficulty staying asleep	□	□	□	□	_____
Energy crashes	□	□	□	□	_____
Fatigue/lack of energy	□	□	□	□	_____
Craving salty food	□	□	□	□	_____
Exhausted easily	□	□	□	□	_____
Sensitive to weather changes	□	□	□	□	_____
Loss of sex drive	□	□	□	□	_____
Erection or potency problems	□	□	□	□	_____
Loss of early morning erection	□	□	□	□	_____
Dark circles under eyes	□	□	□	□	_____
Wounds heal slowly	□	□	□	□	_____
Body tender/sensitive to touch	□	□	□	□	_____
Feel puffy/swollen all over	□	□	□	□	_____
Does your mind race at bedtime	□	□	□	□	_____
Hair Loss	□	□	□	□	_____

Please write down any Questions you have at this point in the therapy.

_____

_____

_____

_____

_____

_____

_____

If you would like us to share this information with your physician, please initial: _____

Signature: _____ Date: _____

Your signature acknowledges your understanding of Riley's Drugs Notice of Privacy Practices according to HIPPA regulations. It does not acknowledge your agreement of any restrictions you may have requested regarding your Protected Health Information.

Patient Name: _____ Today's Date:_____