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
## Medical History

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: _____

**Allergies:** Please check all that apply.

□ No Known Allergies
□ Penicillin □ Morphine □ Dye allergies □ Pet allergies
□ Codeine □ Aspirin □ Nitrate Allergy □ Seasonal (pollen) allergies
□ Sulfa drug □ Food allergies Other: _____

Please describe the allergic reaction you experienced and when it occurred?

_____
_____

**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.

_____
_____
_____

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

□ Heart disease (example: Congestive Heart Failure)
□ High Cholesterol or lipids (example: Hyperlipidemia)
□ High Blood Pressure (example: Hypertension)
□ Cancer
□ Ulcers (stomach, esophagus)
□ Thyroid disease
□ Hormonal Related Issues
□ Lung condition (example: asthma, emphysema, COPD)
□ Blood Clotting Problems
□ Diabetes
□ Arthritis or joint problems
□ Depression
□ Epilepsy
□ Headaches/migraines
□ Eye Disease (glaucoma, ect.)
□ Other: Please List: _____

_____
_____

Patient Name: _____ Today's Date:_____

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

_____
_____
_____
_____
_____
_____

**List Hormones previously taken.** Date Started Date Stopped Reason

_____
_____
_____
_____

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

Prostate Cancer □ No □ Yes Family member(s) _____
Other Cancer □ No □ Yes Family member(s) _____
Heart Disease □ No □ Yes Family member(s) _____
Osteoporosis □ No □ Yes Family member(s) _____
Diabetes □ No □ Yes Family member(s) _____

**Have you had any of the following tests performed?** Check those that apply and note the date of last test.

Prostate Exam □ No □ Yes Date: _____
Cholesterol screen □ No □ Yes Date: _____
Thyroid Panel □ No □ Yes Date: _____
Colonoscopy □ No □ Yes Date: _____
Bone Density scan □ No □ Yes Date: _____
Blood Pressure check □ No □ Yes Date: _____
Blood Glucose □ No □ Yes Date: _____

**Habits:**

My appetite is: □ Poor □ Fair □ Good □ Very Good □ Out of Control
My daily diet usually includes: list your typical meals
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Dietary Restictions:_____
Do you need help with your diet? □ No □ Yes
Do you get at least 20 minutes of relaxation each day? □ No □ Yes
Do you get a restful night sleep? □ No □ Yes
How much water do you drink daily? _____

How often and how much?

Do you use tobacco? □ No □ Yes _____
Do you use alcohol? □ No □ Yes _____
Do you use caffeine? □ No □ Yes _____

Patient Name: _____ Today's Date:_____

**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 | □ | □ | □ | □ | _____ |

**How did you arrive at the decision to consider Bio-Identical Hormone Replacement Therapy?**

Doctor □ Self □ Friend/Family Member □ Other □ _____

**What are your Goals with taking BHRT?**

_____

_____

_____

_____

**Please write down any Questions you have about Bio-Identical Hormone Replacement 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:_____