

CENTRAL COMPOUNDING CENTER
Male Consultation Health Questionnaire

Please complete and bring with you to your appointment. Please bring **ALL** of your medications, vitamins, nutritional supplements, herbals, etc. that you are taking to your appointment.

Today's Date _____

How did you hear about our consultative services? _____

Patient Information

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Email address _____

Birthdate _____ Current Age _____ Height _____ Weight _____

Lifestyle Information

	Do You Use?	If yes, how often and how much?
Tobacco	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Caffeine-Cola drinks, tea, coffee?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you exercise regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you practice any stress management techniques?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Health Care Provider Information

Are you currently under the care of a physician? Yes No

If yes, please list each doctor from whom you seek care, including address and phone number.

Provider Name: _____

Address: _____ Phone: _____

Provider Name: _____

Address: _____ Phone: _____

Allergies

Please list and describe any allergies that you have to medications/foods/etc:

Medications (Prescription/Over-the-Counter) & Nutritional Supplements

Please list ALL medications (prescriptions, over-the-counter, vitamins, supplements, herbals, etc), which you take regularly and as needed. Please list the dose as well. If you need additional space, use the back of this page.

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

10. _____
11. _____
12. _____

Dietary Information

How many times do you eat out during a week (7 days)? _____

Are there any foods you crave? Yes No If yes, please list below.

Please describe your typical eating patterns:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

How much water do you drink daily? _____

What is the source of water? Bottled water Well water
 City water Filtered

Medical Conditions/Diseases

Please list any diagnosed medical conditions that you have and approximate date of diagnosis. If you need additional space, use the back of this page.

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

Family Medical History

Father (Living/Deceased) Age_____

Medical History_____

Mother(Living/Deceased) Age_____

Medical History_____

Brother/Sister(Living/Deceased) Age_____

Medical History_____

Brother/Sister(Living/Deceased) Age_____

Medical History_____

Brother/Sister(Living/Deceased) Age_____

Medical History_____

Brother/Sister(Living/Deceased) Age_____

Medical History_____

List and Explanation of Symptoms

Have you experienced any of the following symptoms recently? Please circle the number that best describes your experiences, with 1 being Extremely Mild and 10 being Extremely Severe.

Anxiety 1 2 3 4 5 6 7 8 9 10
Describe _____

Breast tenderness 1 2 3 4 5 6 7 8 9 10
Describe _____

Burn out 1 2 3 4 5 6 7 8 9 10
Describe _____

Constipation 1 2 3 4 5 6 7 8 9 10
Describe _____# of bowel movements per day

Depression 1 2 3 4 5 6 7 8 9 10
Describe _____

Dry Hair/Skin 1 2 3 4 5 6 7 8 9 10
Describe _____

Erection problems 1 2 3 4 5 6 7 8 9 10
Describe _____

Fatigue 1 2 3 4 5 6 7 8 9 10
Describe _____

Fuzzy Thinking 1 2 3 4 5 6 7 8 9 10
Describe _____

Headaches 1 2 3 4 5 6 7 8 9 10
Describe _____

Heart Palpitations 1 2 3 4 5 6 7 8 9 10
Describe _____

Height Loss 1 2 3 4 5 6 7 8 9 10
Describe _____

Insomnia 1 2 3 4 5 6 7 8 9 10

Describe _____

Irritability 1 2 3 4 5 6 7 8 9 10
Describe _____

Joint aches/pains 1 2 3 4 5 6 7 8 9 10
Describe _____

Loss of muscle mass 1 2 3 4 5 6 7 8 9 10
Describe _____

Low Concentration 1 2 3 4 5 6 7 8 9 10
Describe _____

Low Libido 1 2 3 4 5 6 7 8 9 10
Describe _____

Low Thyroid 1 2 3 4 5 6 7 8 9 10
Describe _____

Memory Loss 1 2 3 4 5 6 7 8 9 10
Describe _____

Overwhelmed 1 2 3 4 5 6 7 8 9 10
Describe _____

Physical stamina 1 2 3 4 5 6 7 8 9 10
Describe _____

Slow recovery from illness 1 2 3 4 5 6 7 8 9 10
Describe _____

Stress 1 2 3 4 5 6 7 8 9 10
Describe _____

Waist Circumference : Increased or Decreased
Describe _____

Weight Gain 1 2 3 4 5 6 7 8 9 10
Describe _____

Other 1 2 3 4 5 6 7 8 9 10
Describe _____

Other 1 2 3 4 5 6 7 8 9 10
Describe _____

Please write down any issues/questions you wish to discuss with the Pharmacist in advance so that we make sure to cover all of your concerns.

The information I have provided is correct to the best of my knowledge. In the course of making recommendations to your health care provider, we will share any pertinent labs that we may have. I authorize you (Pharmacist) to have access to labs or medical records from my other health care providers if needed to help develop recommendations. In addition, I authorize my other health care providers to provide any labs results requested to Central Compounding Center.

Printed Name _____

Signature _____ Date _____

Pharmacist's Notes

Consultation #1 Date _____

Subject/Objective

Assessment/Plan

Consultation #2 Date _____

Subjective/Objective

Assessment/Plan

Consultation #3 Date _____

Subjective/Objective

Assessment/Plan