College Pharmacy
Compounding Specialists

Men's Health Hormone Self-Assessment

Knowledge Changes Everything: Quality | Innovation | Experience | Since 1974

Consulting Pharmacist: _____ Consultation Date: _____

How did you hear about College Pharmacy's Hormone Self-Assessment & Consultation Services?

Advertisement _____ Books/Articles_____
Another Patient _____ Website _____
Healthcare Provider _____ Other (please specify)_____

Personal Information

Patient Name: _____ Date: _____

Address: _____DOB_____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Do you understand what Biologically Identical Hormone Replacement is? _____

Do you understand the risks associated with the use of Biologically Identical Hormone Replacement? _____ **It is recommended that you consult with your physician regarding these risks.*

What are your goals for Biologically Identical Hormone Replacement? _____

_____

_____

Medical History

Family History	**(relationship)**
Cancer (type) _____	_____
Heart Disease	_____
Diabetes	_____
High Blood Pressure	_____
Other	_____

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Medical History

Personal History

- ☐ Heart Disease
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Smoking History
- ☐ Impaired Liver Function
- ☐ Stroke
- ☐ Adult Mumps
- ☐ Prostate Operation
- ☐ Vasectomy
- ☐ Orchitis (testicular inflammation)
- ☐ Cancer (type) _____
- ☐ Persistent Urinary Tract Infections
- ☐ Other Testicular Problems
- ☐ Other _____
- ☐ Other _____

Cholesterol Serum:_____Date:_____ Triglycerides:____ HDL:____ LDL:____ Chol/HDL Ratio:_____

Date of Last Prostate Exam: _____ PSA Results: _____

Current Health Care Provider/s:_____

To what degree do you experience the following?

	None	Slightly	Moderate	Severe	Extreme
Fatigue or loss of energy					
Depression, low or negative mood					
Irritability, anger or bad temper					
Anxiety or nervousness					
Lack of motivation					
Loss of memory or concentration					
Impotence / Decreased erections					
Inability to ejaculate					
Dry skin on face or hands					
Weight gain / Increased Abdominal Fat					
Backache, joint pains or stiffness					
Loss of muscle mass/tone					
Decreased Urine Flow					
Increased Urinary Urge					
Sleep Disturbances					
Decreased Libido					
Thinning Hair					
Bone Loss					
Night Sweats					
Brain Fog/ Burned out Feeling					
Decreased Stamina					

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General Health & Lifestyle

General Health: ☐ Good ☐ Fair ☐ Poor

Height: _____ Weight:_____ Do you exercise, describe:_____

Surgery: **Date of Surgery:**

☐ _____ _____
☐ _____ _____
☐ _____ _____
☐ _____ _____

Current Medications & Reason: _____

_____

_____

Current Vitamins / Minerals / Herbal Formulas: _____

_____

_____

Prior Hormone Replacement Therapy History: (include dates of use) _____

_____

Known Allergies (drug, food, pollen):_____

Are you crrently following a special diet (Gluten Free, Casien Free, Arkins, Paleo, etc):_____

_____

Do you eat/drink soy: _____Caffeine/amount per day:_____ Alcohol/amount per day:_____

Notes and/or Questions:

_____

_____

_____

BHRT Considerations

BHRT Dosage Form

Would you like your prescription filled using a:

- ☐ Topical gel applied once daily to inner arms or thighs.
- ☐ Sublingual tablets dissolved under the tongue twice daily.

It is recommended that baseline hormone levels be checked. This can be achieved by testing blood, urine, or saliva. If recommended, we suggest that you test for the following hormones:

Men

a. PSA
b. Estradiol (E2)
c. Testosterone (Free & Total)
d. DHT
e. DHEA (Sulfate)
f. Vitamin D3 (25 Hydroxy)
g. Thyroid: TSH, T3, and T4

Optional: Reverse T3 (practitioner discretion)

If you have recently (2 to 3 months) had a blood, urine, or saliva hormone test, please attach the results to your questionnaire.

Where to go from here:

- ☐ I would like a recommendation from a pharmacist.
- ☐ I will take this completed questionnaire to my practitioner.
- ☐ I will contact my practitioner about further lab testing.

Notes and/or Questions:

_____

_____

Where to send your completed Hormone Self-Assessment:

1.) You will need to call College Pharmacy to set-up a consultation.

Email: The pharmacist that you schedule a consultation with can provide you with their email address.
Do not email this form to info@collegepharmacy, inforequest@collegepharmacy, or hipaamail@collegepharmacy.

Fax: Confirm with the consulting pharmacist that you will be sending this form via fax.
Toll-Free:(800) 556-5893 Colorado Springs Area: (719) 262-0035

Local? You can bring it with you!

Waiver & Privacy Information

Waiver **Last Revised May 2012**

I hereby release College Pharmacy, all its employees and pharmacists from any and all liability whatsoever associated with or connected to my Biologically Identical Hormone Replacement Therapy (BHRT) consultation and/or use of BHRT. I acknowledge that I am legally responsible for and aware of the potential side-effects associated with BHRT. I understand that no doctor, nurse, pharmacist, or administrative personnel can guarantee that BHRT will provide the results I seek. I am participating in this program by my own choice, and assume all responsibility for my use of BHRT.

I fully understand that it is my responsibility to have an annual physical examination along with appropriate laboratory testing. I am currently under the medical supervision of a primary care physician. I have been advised in this hormone self-assessment about the increased risks of heart disease, myocardial infarction, stroke, and breast cancer possibly associated with the use of BHRT. I have answered truthfully all of the questions on this questionnaire.

Signed_____ Date _____

Privacy Agreement

Starting April 14, 2003, healthcare providers must comply with a new set of federal regulations. The regulations are part of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), which addresses your rights to privacy and handling of Protected Health Information ("PHI").

Respect for your privacy is a top priority at College Pharmacy. Concern for your privacy rights goes hand in hand with our focus on maintaining and improving your health. One of the regulations requires that all of our patients receive our Notice of Privacy Practices at the time of, or prior to, our providing healthcare services. We are also required to ask each patient to sign an acknowledgment indicating receipt of this notice.

In an effort to ensure that there will not be a delay on your first prescription from College Pharmacy, and that you are provided with prompt service, we ask that you read our Notice of Privacy Practices, sign the Acknowledgment form at the bottom of the page and return to us.

For Privacy Agreement Questions, pelase contact:
Privacy Officer
College Pharmacy
3505 Austin Bluffs Parkway, Suite 101
Colorado Springs, CO 80918
Fax: 719/262-0035 or 800/556-5893
e-mail: hipaamail@collegepharmacy.com

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

College Pharmacy 3505 Austin Bluffs Pkwy #101 Colorado Springs, CO 80918

_____ _____ _____
Patient Last Name Patient First Name M.I.

_____ _____ _____
Street Address City State

_____ (_____)_____
Zip Telephone Number

My signature below certifies that I have been provided with a copy of the above named pharmacy's Notice of Privacy Practices.

_____ _____
Patient Signature (or authorized representative) Date