Retail • Compounding • Home Infusion • Institutional Pharmacy Services
Health and Wellness • Drug Benefit Management

www.wilsonpharmacy.com
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(423) 926-6154

Men's Health Profile/Questionnaire

Name: ________________________________ Date: __________________ Phone:_________________

Address: ____

Email:_____________________________ Date of Birth: _____________ Height: ________ Weight: _______

Primary Physician: ______________________ Have you discussed hormone therapy with him/her? **Yes No**

Medical & Social History: Please check the following that apply to you.

___High Blood Pressure
___High Cholesterol
___Cardiovascular Disease
___Diabetes Mellitus
___Osteoporosis
___Benign Prostatic Hyperplasia
___Tobacco Use
___Asthma/COPD
___Alcohol Use
___Erectile Dysfunction
___Insomnia
___Malnutrition
___Depression
___Cancer: __________________________
___Other: ___________________________

Medication History: List all prescription and non-prescription medications that you are taking. (Include vitamins, herbals and supplements.)

____
____
____
____
____
____
____

Drug Allergies: ____
____

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

1. Do you feel more fatigued and/or tired than usual? **Yes No**
   If yes, circle: **Mild Moderate Severe**

2. Have you noticed a decrease in your muscle mass? **Yes No**
   If yes, circle: **Mild Moderate Severe**

3. Have you experienced a loss in muscle strength? **Yes No**
   If yes, circle: **Mild Moderate Severe**

4. Have you experienced an increase in joint and/or muscle pains? **Yes** **No**
If yes, circle: **Mild** **Moderate** **Severe**

5. Have you noticed an increase in your waist size? **Yes** **No**
If yes, circle: **Mild** **Moderate** **Severe**

6. Do you have trouble losing weight? **Yes** **No**
If yes, circle: **Mild** **Moderate** **Severe**

7. Have you experienced a loss in height? **Yes** **No**
If yes, circle: **Mild** **Moderate** **Severe**

8. Do you have a decrease in your sex drive? **Yes** **No**
If yes, circle: **Mild** **Moderate** **Severe**

9. Have you experienced difficulty in establishing and/or maintaining full erections? **Yes** **No**
If yes, circle: **Mild** **Moderate** **Severe**

10. Do you have a decrease in spontaneous early morning erections? **Yes** **No**
If yes, circle: **Mild** **Moderate** **Severe**

11. Have you experienced changes in your usual sleep pattern? **Yes** **No**
If yes, circle: **Mild** **Moderate** **Severe**

12. Do you feel a decrease in your mental sharpness? **Yes** **No**
If yes, circle: **Mild** **Moderate** **Severe**

13. Have you had trouble concentrating? **Yes** **No**
If yes, circle: **Mild** **Moderate** **Severe**

14. Do you experience less enjoyment in personal interests and hobbies? **Yes** **No**
If yes, circle: **Mild** **Moderate** **Severe**

15. I am ______ years old. I feel ______ years old.

16. How did you hear about our Men's Health/Bio-Identical Hormone Replacement Program?
Radio **Billboard** **Friend** **Newspaper** **Doctor** **Other**_____________

17. What are your major complaints or symptoms that led you to pursue hormone replacement therapy?____
____
____
____
____

Upon completion of this form, please call (423) 926-6154, ext. 1159 to schedule a consult with a Wilson Pharmacy Hormone Therapy Specialist. You may fax the form to (423) 232-9875, ATTN: Keri OR bring the form with you to your appointment.