

Men's Health Evaluation Form

Allcare

PHARMACY & COMPOUNDING

Today's Date: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____
Street City State Zip

Phone: _____ Email: _____

Height: _____ Weight: _____ Desired Weight: _____

Occupation: _____ Hobbies: _____

How often and how much?

Do you use tobacco/nicotine? Yes No _____

Do you use alcohol? Yes No _____

Do you use caffeine? Yes No _____

Do you exercise? Yes No _____

How long have you exercised? (months/years) _____

Type of exercise preferred. _____

If yes, please elaborate (dates/frequency):

Have you ever had a panic attack? Yes No _____

Do you have OCD? Yes No _____ No

Any diagnosis of mental illness? Yes _____ No

Ever had a head injury/concussion? Yes _____

How frequent are your bowel movements? _____

Typical # of hours of sleep per night: _____ Normal bedtime: _____

Uninterrupted? Yes No Time and reason for interruption: _____

Do you wake rested or tired (even when getting 7-8 hours of sleep)? _____

Are you or have you ever been a night shift worker? Yes No

If yes, please describe when and for how long: _____

My diet is:

_____ Super healthy _____ Mostly healthy _____ Needs work _____ Terrible

What would you like to change about your current dietary choices? _____

Allergies: Please list any allergies and describe the reaction that occurred.

Drugs: _____

Foods: _____

Other: _____

Patient Name: _____

Over-the-Counter Medication History: Please list all non-prescription medications that you are taking. (Include vitamins, herbals and supplements): _____

CBD/THC Use: Please list any products used and frequency: _____

Medical Conditions/Diseases: Please list any conditions/diseases that you have been diagnosed with or suffer from. (Examples include heart disease, high blood pressure, depression, benign prostatic hyperplasia, erectile dysfunction, etc.) _____

Have you ever tested positive for Epstein-Barr virus or Lime Disease? Yes No

If yes, please elaborate (dates/current status): _____

When was your last physical exam? _____ When was your last colonoscopy? _____

Any bowel habit changes or blood in stool? _____

Current Prescription Medications:

Medication Name and Strength	Date Started	How Often per Day	Medical Condition Being Treated
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Please indicate if you are experiencing the following symptoms:

	Absent	Mild	Moderate	Severe
Weight gain	_____	_____	_____	_____
Dry skin/hair	_____	_____	_____	_____
Hair loss	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Moodiness or irritability	_____	_____	_____	_____
Headaches	_____	_____	_____	_____
Difficulty falling asleep	_____	_____	_____	_____
Difficulty staying asleep	_____	_____	_____	_____
Fatigue	_____	_____	_____	_____

Patient Name: _____

	Absent	Mild	Moderate	Severe
Loss of memory	_____	_____	_____	_____
Foggy thinking	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Decreased sex drive	_____	_____	_____	_____
Stress	_____	_____	_____	_____
Sugar cravings	_____	_____	_____	_____
Difficulty losing weight	_____	_____	_____	_____
Decreased height	_____	_____	_____	_____
Difficulty establishing and/or maintaining full erections	_____	_____	_____	_____
Decrease in spontaneous early morning erections	_____	_____	_____	_____
Less enjoyment in personal interests and hobbies	_____	_____	_____	_____
Premature ejaculation	_____	_____	_____	_____
Difficulty reaching orgasm	_____	_____	_____	_____
Difficulty urinating or weak stream	_____	_____	_____	_____
Frequent nighttime urination	_____	_____	_____	_____
Decreased muscle mass	_____	_____	_____	_____
Bone loss	_____	_____	_____	_____
Bone fractures	_____	_____	_____	_____
Other symptoms: _____				

I am _____ years old.

I feel _____ years old.

What are your goals for taking hormone replacement therapy?

1. _____
2. _____

Doctor who we should contact for this therapy:

Name: _____

Phone: _____

Address: _____

Street

City

State

Zip

*** Please include a copy of all relevant lab work, especially PSA and hormone levels, that you have recently obtained.