

## Andropause Self Assessment Questionnaire

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ DOB \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

### How did you hear about Biologically Identical Hormone Replacement and College Pharmacy?

Advertisement _____	Books/Articles _____
Another Patient _____	Internet _____
Healthcare Provider _____	Other (please specify) _____

Do you understand the risks associated with the use of Biologically Identical Hormone Replacement? \_\_\_\_\_

What are your goals for Biologically Identical Hormone Replacement? \_\_\_\_\_

	Self	Duration	Family History (who)
Cancer (type) _____	_____	_____	_____
Heart Disease	_____	_____	_____
Diabetes	_____	_____	_____
High Blood Pressure	_____	_____	_____

<b>Medical History (for SELF)</b>	<b>Yes</b>	<b>No</b>
Persistent Urinary Tract Infections	_____	_____
Adult Mumps	_____	_____
Orchitis (testicular inflammation)	_____	_____
Other Testicular Problems	_____	_____
Prostate Operation	_____	_____
Vasectomy	_____	_____
Impaired Liver Function	_____	_____
Smoking History	_____	_____

**General Health:** Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**Current Health Care Provider/s:** \_\_\_\_\_  
\_\_\_\_\_

**Current Medications:** (including vitamins, herbals, etc.): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies:** (drug, food, pollen): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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					
Inability to ejaculate					
Dry skin on face or hands					
Weight gain					
Backache, joint pains or stiffness					
Loss of muscle mass/tone					

**Notes &/or Questions:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 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 sometimes 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: Estradiol (E2), Free and Total Testosterone, DHEA (Sulfate), PSA, DHT, Vitamin D3 (25 Hydroxy) and Thyroid (TSH, T3, T4).**

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 would like to order the appropriate Hormone Saliva Testing from College Pharmacy.
- I will contact my practitioner about further lab testing.

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## Notes and/or Questions:

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