NEXTGEN Rx
COMPOUNDING PHARMACY

MALE CONSULTATION FORM

Today's Date:

PERSONAL INFORMATION

Name: _____ Are you a Vitality Program Member? YES NO

Street Address: _____

State: _____ Zip Code: _____

Phone: _____ Work Phone: _____

Fax: _____ Email: _____

Height: _____ Weight: _____ BMI (Pharmacist will calculate): _____

Date of Birth: _____

Waist Circumference: _____ Waist/Hip Ratio: _____

MEDICAL STATUS

Primary Health Care Practitioner/Physician: _____

Phone: _____ Fax: _____

Primary Health Care Practitioner/Physician Address: _____

City: _____ State / Province / Region: _____ Zip Code: _____

Other Physician's Currently Seeing: _____

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General Health: ◯ Excellent ◯ Good ◯ Fair ◯ Poor

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

◯ High Blood Pressure	◯ Benign Prostatic Hyperplasia	◯ Insomnia
◯ High Cholesterol	◯ Tobacco Use	◯ Malnutrition
◯ Cardiovascular Disease	◯ Asthma/COPD	◯ Depression
◯ Diabetes Mellitus	◯ Alcohol Use	◯ Cancer
◯ Osteoporosis	◯ Erectile Dysfunction	◯ Other

If you checked ***cancer***, please explain: _____

If you checked ***other***, please explain: _____

Names of ALL prescription medications, taken in last 6 months. Include strength and how you take them:

_____

_____

_____

Indicate any herbal products you have taken (i.e. Evening Primrose Oil (EPO), Chaste Tree Berry, Dong Quai, Black Cohosh Ginseng, Melatonin, etc., other):

_____

_____

_____

Name all vitamins, supplements, non-prescription medicines, or other OTC products that you are currently using:

_____

_____

_____

Drug Allergies:

_____

_____

_____

MALE CONSULTATION FORM

Family History: List Important Diseases

Mother: _____

◯ Living ◯ Deceased

Father: _____

◯ Living ◯ Deceased

Brothers: _____

◯ Living ◯ Deceased

Sisters: _____

◯ Living ◯ Deceased

Aunts: _____

◯ Living ◯ Deceased

Uncles: _____

◯ Living ◯ Deceased

Paternal Grandma: _____

◯ Living ◯ Deceased

Paternal Grandpa: _____

◯ Living ◯ Deceased

Maternal Grandma: _____

◯ Living ◯ Deceased

Maternal Grandpa: _____

◯ Living ◯ Deceased

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QUESTIONNAIRE

	NOT APPLICABLE	MILD	MODERATE	SEVERE
Do you feel more fatigued and/or tired than usual?				
Have you noticed a decrease in your muscle mass?				
Have you experienced a loss in muscle strength?				
Have you experienced an increase in joint and/or muscle pains?				
Have you noticed an increase in your waist size?				
Do you have trouble losing weight?				
Have you experienced a loss in height?				
Do you have a decrease in your sex drive?				
Have you experienced difficulty in establishing and/or maintaining full erections?				
Have you experienced changes in your usual sleep pattern?				
Do you feel a decrease in your mental sharpness?				
Have you had trouble concentrating?				
Do you experience less enjoyment in personal interests and hobbies?				

I am _____ years old

I feel _____ years old