

# Medical History Form

**\$100 Non-Refundable  
Deposit Due at Appointment  
Scheduling!**

Please return your form to the Pharmacy when you have finished.  
The Pharmacist will meet with you to review your information. Thank you.

## 1. Patient Information:

Today's Date: \_\_\_\_\_  
Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_  
Zip: \_\_\_\_\_  
Home/Work Phone#: \_\_\_\_\_ Email address: \_\_\_\_\_  
Payment type: \_\_\_\_\_ Credit Card (MC/Visa/Discover) \_\_\_\_\_ Cash \_\_\_\_\_ Other  
Credit Card # \_\_\_\_\_ Expiration \_\_\_\_\_  
Gender: Male Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_

## 2. Lifestyle Information:

	Do you use? Yes or No	If Yes, how often and how much?
Tobacco (smoke, chew, dip)		
Alcohol (beer, wine, hard liquor)		
Caffeine (cola drinks, tea, coffee)		

**IMPAIRMENTS:** Check if you have any of the following:

Physical impairment  Visual Impairment  Hearing Impairment

**EXERCISE:** Do you exercise regularly?  YES  NO

If YES, describe what you do and how often:

**STRESS MANAGEMENT:** Do you practice any stress management techniques?  YES  NO

If YES, describe what you do and how often:

**DIET:** Describe your typical daily food intake:

First Meal:

Second Meal:

Third Meal:

Any snacks/other:

**1. Doctor Information:** Are you currently under the care of a physician?  YES  NO

If YES, please list each doctor from whom you seek care, including address and phone number, if known:

Doctor name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Doctor name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Doctor name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Name: \_\_\_\_\_ SS#: \_\_\_\_\_

**72 Hour Notice  
Required for Cancellation!**

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**4. Allergies: Please check all that apply:**

- penicillin                       morphine                       dye allergies                       pet allergies  
 codeine                       aspirin                       nitrate allergy                       seasonal (pollen) allergies  
 sulfa drug                       food allergies                       no known allergies                      other: \_\_\_\_\_

Please describe the allergic reaction you experienced and when it occurred:

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**5. Over-the-counter (OTC) issues:**

**Please check all products that you use occasionally or regularly. Check all that apply.**

- Pain reliever                       Combination product (cough+cold reliever)(example: Triaminic DM®)  
 Aspirin                       Sleep Aids (examples: Excedrin PM®, Unisom®, Sominex®, Nytol®)  
 Acetaminophen (example: Tylenol®)                       Antidiarrheals (examples: Imodium®, Pepto Bismol®, Kaopectate®)  
 Ibuprofen (example: Motrin IB®)                       Laxatives/stool softeners (examples: Doxidan®, Correctol®, etc.)  
 Naproxen (example: Aleve®)                       Diet aids/weight loss products (examples: Doxatrim®)  
 Ketoprofen (example: Orudis KT®)                       Antacids (examples: Maalox®, Mylanta®)  
 Cough Suppressant (example: Robitussin DM®)                       Acid Blockers (examples: Tagamet HB®, Pepcid AC®, Zantac 75®)  
 Antihistamine (example: Chlor-Trimeton®)                       Others (please list:)  
 Decongestant product (example: Sudafed®)                      \_\_\_\_\_

**— Nutritional/Natural Supplements: Please identify and list the products you are using:**

- vitamins (examples: multiple or single vitamins such as B complex, E, C, beta carotene)  
\_\_\_\_\_  
 minerals (examples: calcium, magnesium, chromium, colloidal minerals, various single minerals)  
\_\_\_\_\_  
 herbs (examples: Ginseng, Ginkgo Biloba, Echinacea, other herbal medicinal teas, tinctures, remedies, etc.)  
\_\_\_\_\_  
 enzymes (examples: digestive formulas, papaya, bromelain, CoEnzyme Q10, etc.)  
\_\_\_\_\_  
 nutrition/protein supplements (examples: shark cartilage, protein powders, amino acids, fish oils, etc.)  
\_\_\_\_\_  
 others (glucosamine, etc.)  
\_\_\_\_\_
- 

**6. Medical Conditions/Diseases: Please check all that apply to you.**

- Heart Disease (example: Congestive Heart Failure)                       Lung condition (examples: asthma, emphysema, COPD)  
 High cholesterol or lipids (example: Hyperlipidemia)                       Diabetes  
 High blood pressure (example: Hypertension)                       Arthritis or joint problems  
 Cancer                       Depression  
 Ulcers (stomach, esophagus)                       Epilepsy  
 Thyroid disease                       Headaches/migraines  
 Hormonal Related Issues                       Eye Disease (glaucoma, etc.)  
 Blood Clotting Problems                       Others (please list:)
- 

**7. Prescription Medications:**

Please list all prescription medications you are currently using. Be sure to include any mail order or physician samples.

<u>Medication Name</u>	<u>Dose</u>	<u>How many times per day?</u>	<u>Doctor</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____

Patient Name: \_\_\_\_\_ SS#: \_\_\_\_\_

**FAMILY HISTORY:**

1. Please list family members - and their age - who have had serious diseases such as diabetes, heart disease, cancer, osteoporosis, etc.

Disease: \_\_\_\_\_ Relation: \_\_\_\_\_ Age: \_\_\_\_\_

Disease: \_\_\_\_\_ Relation: \_\_\_\_\_ Age: \_\_\_\_\_

Disease: \_\_\_\_\_ Relation: \_\_\_\_\_ Age: \_\_\_\_\_

Disease: \_\_\_\_\_ Relation: \_\_\_\_\_ Age: \_\_\_\_\_

1. Please list any family members who have died from serious diseases.

Disease: \_\_\_\_\_ Relation: \_\_\_\_\_ Age: \_\_\_\_\_

Disease: \_\_\_\_\_ Relation: \_\_\_\_\_ Age: \_\_\_\_\_

Disease: \_\_\_\_\_ Relation: \_\_\_\_\_ Age: \_\_\_\_\_

Disease: \_\_\_\_\_ Relation: \_\_\_\_\_ Age: \_\_\_\_\_

# STATEMENT OF MEDICAL NEED

Patient Name:		DOB:	
Address:		Phone: (    )	
City:	State:	Zip:	
ICD-9:	ICD-9:	ICD-9:	ICD-9:
<b>Service/Intervention</b> <input type="checkbox"/> Additional Medication Counseling <input type="checkbox"/> Injection Training Specify Device: _____		<input type="checkbox"/> Medication Review & Evaluation <input type="checkbox"/> Device Training Specify Device: _____ <input type="checkbox"/> Body Fat Analysis (electrolipograph) <input type="checkbox"/> Weight Monitoring	
<b>Asthma/COPD Coordination of Care</b> <input type="checkbox"/> General Asthma/COPD Education <input type="checkbox"/> Childhood Asthma Education <input type="checkbox"/> Pregnancy & Asthma Education <input type="checkbox"/> Environmental Control <input type="checkbox"/> Allergen Avoidance <input type="checkbox"/> Smoking & Asthma/COPD <input type="checkbox"/> MDI/Spacer Education <input type="checkbox"/> Peak Flow Monitoring <input type="checkbox"/> Asthma/COPD Care Diary		<b>Diabetes Coordination of Care</b> <input type="checkbox"/> Diabetes Mellitus Education (circle: type 1 type 2) <input type="checkbox"/> Lifestyle Modifications (diet, exercise, stress mgmt) <input type="checkbox"/> Complications of Diabetes <input type="checkbox"/> Hypo/Hyperglycemia Management <input type="checkbox"/> Eye & Foot Care <input type="checkbox"/> Injection Device Training <input type="checkbox"/> Blood Glucose Monitor Training <input type="checkbox"/> Home Blood Glucose Monitoring Education <input type="checkbox"/> Glucose Monitoring Diary	
<b>Hyperlipidemia Coordination of Care</b> <input type="checkbox"/> Dyslipidemia Education <input type="checkbox"/> Complications of Dyslipidemia <input type="checkbox"/> Risk Factors Education <input type="checkbox"/> Lifestyle Modifications (diet, exercise, stress mgmt) <input type="checkbox"/> Total Cholesterol Monitoring <input type="checkbox"/> Lipid Profile Monitoring (fasting) <input type="checkbox"/> Framingham Risk Assessment <input type="checkbox"/> Body Fat Analysis (electrolipograph) <input type="checkbox"/> Weight Monitoring <input type="checkbox"/> Blood Pressure Monitoring		<b>Cardiovascular Coordination of Care</b> <input type="checkbox"/> Cardiac Disease Education <input type="checkbox"/> Hypertension Education <input type="checkbox"/> Lifestyle Modifications (diet, exercise) <input type="checkbox"/> Sodium Restriction <input type="checkbox"/> Alcohol & Tobacco Elimination <input type="checkbox"/> Relaxation & Stress Reduction Techniques <input type="checkbox"/> Body Fat Analysis (electrolipograph) <input type="checkbox"/> Weight Monitoring <input type="checkbox"/> Blood Pressure Monitoring <input type="checkbox"/> Anticoagulation Monitoring (PT/INR)	
<b>Anticoagulation Coordination of Care</b> <input type="checkbox"/> Anticoagulation Monitoring (PT/INR) <input type="checkbox"/> Coagulation Meter Use Training <input type="checkbox"/> Detailed Anticoagulation Education <input type="checkbox"/> Atrial Fibrillation Education <input type="checkbox"/> DVT/PE Education <input type="checkbox"/> Dietary Concerns <input type="checkbox"/> OTC and Natural Product Education <input type="checkbox"/> Lifestyle Modifications (ADL, exercise)		<b>Natural H.R.T. Coordination of Care</b> <input type="checkbox"/> Lifestyle Modifications <input type="checkbox"/> Medication Dosage Calculations <input type="checkbox"/> Dosage Form Review <input type="checkbox"/> Dietary Concerns (calcium, Vitamin D, etc.) <input type="checkbox"/> OTC and Natural Product Education <input type="checkbox"/> Risk Factors Education <input type="checkbox"/> Lipid Profile Monitoring (TC, HDL, LDL, TG) Other: _____	

I have asked \_\_\_\_\_ Pharmacy to evaluate this patient and recommend solutions to the patient's problem(s).

Also, I request that a \_\_\_\_\_ pharmacist and/or nurse implement programs to correct the problem(s) under his/her control.

**Goals and Duration of Intervention:**

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(Continue on back if necessary)

“I consider this program to be a necessary part of this patient's medical care.”

\_\_\_\_\_  
Physician's Signature  
Printed Name \_\_\_\_\_

\_\_\_\_\_  
Date  
UPIN# \_\_\_\_\_

Patient Name: _____	SS#: _____
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# Question Documentation Form

Please write down any questions you may have about Prescription Natural Hormone Replacement Therapy (Rx NHRT), other medications, or any other questions that come up as you read through the materials you have received. Bring this question sheet with you to your consultation so you can discuss this information with your pharmacist / nurse. Thank you.

1.

2.

3.

4.

5.

6.

7.

8.

Patient Name: _____ SS#: _____
Martin Avenue Pharmacy, Inc. • 1247 Rickert Drive • Naperville, IL 60540 • Phone: 630-355-6400
<b>72 Hour Notice Required for Cancellation!</b>

# Male Hormone Screening

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight \_\_\_\_\_

Rate the following as they apply to you. Use the numbers 1-4, with 1 being Rare or Mild, and 4 being Frequent or Severe.

	Rare	Mild	Frequent	Severe
1. Fatigue, tiredness or loss of energy	1	2	3	4
2. Decrease in physical stamina	1	2	3	4
3. Feelings of depression - a sense that work, marriage or recreational activities have lost significance.	1	2	3	4
4. Decreased libido - less desire for sex.	1	2	3	4
5. Erection or potency problems.	1	2	3	4
6. Loss of early morning erection.	1	2	3	4
7. Dry skin on face and hands.	1	2	3	4
8. Increase in waist size - weight gain, especially around mid-section.	1	2	3	4
9. Increased fat distribution in chest area or hips.	1	2	3	4
10. Feeling burned out, loss of motivation.	1	2	3	4
11. Increase in aches, joint and muscle pains.	1	2	3	4
12. Frequent use of alcohol - now or in the past.	1	2	3	4
13. Increased irritability, anger or bad temper.	1	2	3	4
14. Decrease in muscle mass.	1	2	3	4
15. The age you are: _____ The age you feel: _____				

**TURN OVER >>**

What non-prescription drugs are you taking (include vitamins, herbal products, or other supplements)? \_\_\_\_\_

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What medical conditions are you being treated for? \_\_\_\_\_

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What medical conditions have you been treated for in the past 5 years? \_\_\_\_\_

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# *Martin Avenue Pharmacy, Inc.*

***"We Make It Better..."***

**Phone: 630-355-6400**

1247 Rickert Drive • Naperville

Web Site: [www.MartinAvenue.com](http://www.MartinAvenue.com)



Monday to Friday

Saturday

Sunday

9am to 7pm

9am to 4pm

Closed

Just West of 75th St. & Rickert Drive

## *Male Hormone Screening: Part II*

### *Sex Function:*

- Decrease in spontaneous early morning erections.  
1 Rare      2 Mild      3 Frequent      4 Severe
- Decreased libido or desire for sex.  
1 Rare      2 Mild      3 Frequent      4 Severe
- Decrease in fullness of erections.  
1 Rare      2 Mild      3 Frequent      4 Severe
- Decrease in volume of ejaculate or semen.  
1 Rare      2 Mild      3 Frequent      4 Severe
- Decrease in strength of climax or force of muscular pulsations.  
1 Rare      2 Mild      3 Frequent      4 Severe
- Decrease in maintaining full erection.  
1 Rare      2 Mild      3 Frequent      4 Severe
- Decrease in starting erection - or no erection.  
1 Rare      2 Mild      3 Frequent      4 Severe

### *Mental Functions:*

- Spells of mental fatigue or inability to concentrate; feeling burned out.  
1 Rare      2 Mild      3 Frequent      4 Severe
- Tiredness or sleepiness in the afternoon or early evening.  
1 Rare      2 Mild      3 Frequent      4 Severe
- Decrease in mental sharpness, attention, wit.  
1 Rare      2 Mild      3 Frequent      4 Severe
- Change in creativity or spontaneous new ideas.  
1 Rare      2 Mild      3 Frequent      4 Severe
- Decrease in initiative or desire to start new projects.  
1 Rare      2 Mild      3 Frequent      4 Severe
- Decreased interest in past hobbies or new work-related activities.  
1 Rare      2 Mild      3 Frequent      4 Severe

- Decrease in competitiveness.  
1 Rare      2 Mild      3 Frequent      4 Severe
- Change in memory function; increased forgetfulness.  
1 Rare      2 Mild      3 Frequent      4 Severe
- Feeling of depression; a sense that work, marriage, or recreational activities have lost significance.  
1 Rare      2 Mild      3 Frequent      4 Severe

**Musculoskeletal Condition:**

- “Sore-body syndrome” - aches, joint and muscle pains.  
1 Rare      2 Mild      3 Frequent      4 Severe
- Decline in flexibility and mobility; increased stiffness.  
1 Rare      2 Mild      3 Frequent      4 Severe
- Decrease in muscle size, tone, strength.  
1 Rare      2 Mild      3 Frequent      4 Severe
- Decrease in physical stamina.  
1 Rare      2 Mild      3 Frequent      4 Severe
- Decrease in athletic performance.  
1 Rare      2 Mild      3 Frequent      4 Severe
- Back pain; neck pain.  
1 Rare      2 Mild      3 Frequent      4 Severe
- Tendency to pull muscles or get leg cramps.  
1 Rare      2 Mild      3 Frequent      4 Severe
- Development of osteoporosis or inflammatory arthritis (rheumatoid arthritis).  
1 Rare      2 Mild      3 Frequent      4 Severe

**Metabolic or Physical / Disease Problems:**

- Increase in total cholesterol or triglycerides.  
1 Rare      2 Mild      3 Frequent      4 Severe
- Decrease in HDL cholesterol.  
1 Rare      2 Mild      3 Frequent      4 Severe

- Rise in blood sugar level or diabetes onset.  
     1 Rare          2 Mild          3 Frequent          4 Severe
- Rise in blood pressure / diagnosis of hypertension.  
     1 Rare          2 Mild          3 Frequent          4 Severe
- Unexplained weight gain, particularly in the midsection; “beer belly” (waist to hip ration).  
     1 Rare          2 Mild          3 Frequent          4 Severe
- Increased fat distribution in breast area or hips.  
     1 Rare          2 Mild          3 Frequent          4 Severe
- Development of chest pain, or diagnosis of heart disease or blockage of arteries.  
     1 Rare          2 Mild          3 Frequent          4 Severe
- Shortness of breath with activities; worsening of asthma or emphysema.  
     1 Rare          2 Mild          3 Frequent          4 Severe
- Lightheadedness, dizzy spells, or ringing of the ears; new onset of headaches.  
     1 Rare          2 Mild          3 Frequent          4 Severe
- Poor circulation in legs, swelling of ankles, developmental of varicose veins or hemorrhoids.  
     1 Rare          2 Mild          3 Frequent          4 Severe
- Changes in visual acuity, focus reading fine print.  
     1 Rare          2 Mild          3 Frequent          4 Severe

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