Medical History Form

$200 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:**

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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!

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:

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

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

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

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

Medication Name	Dose	How many times per day?	Doctor
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:

Service/Intervention

___ Additional Medication Counseling
___ Injection Training
Specify Device: _____

___ Medication Review & Evaluation
___ Device Training
Specify Device: _____
___ Body Fat Analysis (electrolipograph)
___ Weight Monitoring

___ Compliance Assessment
___ Side Effect Analysis
___ FDA MedWatch® Report
___ Stress/ADE Management
___ Other:

Asthma/COPD Coordination of Care

___ General Asthma/COPD Education
___ Childhood Asthma Education
___ Pregnancy & Asthma Education
___ Environmental Control
___ Allergen Avoidance
___ Smoking & Asthma/COPD
___ MDI/Spacer Education
___ Peak Flow Monitoring
___ Asthma/COPD Care Diary

Diabetes Coordination of Care

___ Diabetes Mellitus Education (circle: type 1 type 2)
___ Lifestyle Modifications (diet, exercise, stress mgmt)
___ Complications of Diabetes
___ Hypo/Hyperglycemia Management
___ Eye & Foot Care
___ Injection Device Training
___ Blood Glucose Monitor Training
___ Home Blood Glucose Monitoring Education
___ Glucose Monitoring Diary

Hyperlipidemia Coordination of Care

___ Dyslipidemia Education
___ Complications of Dyslipidemia
___ Risk Factors Education
___ Lifestyle Modifications (diet, exercise, stress mgmt)
___ Total Cholesterol Monitoring
___ Lipid Profile Monitoring (fasting)
___ Framingham Risk Assessment
___ Body Fat Analysis (electrolipograph)
___ Weight Monitoring
___ Blood Pressure Monitoring

Cardiovascular Coordination of Care

___ Cardiac Disease Education
___ Hypertension Education
___ Lifestyle Modifications (diet, exercise)
___ Sodium Restriction
___ Alcohol & Tobacco Elimination
___ Relaxation & Stress Reduction Techniques
___ Body Fat Analysis (electrolipograph)
___ Weight Monitoring
___ Blood Pressure Monitoring
___ Anticoagulation Monitoring (PT/INR)

Anticoagulation Coordination of Care

___ Anticoagulation Monitoring (PT/INR)
___ Coagulation Meter Use Training
___ Detailed Anticoagulation Education
___ Atrial Fibrillation Education
___ DVT/PE Education
___ Dietary Concerns
___ OTC and Natural Product Education
___ Lifestyle Modifications (ADL, exercise)

Natural H.R.T. Coordination of Care

___ Lifestyle Modifications
___ Medication Dosage Calculations
___ Dosage Form Review
___ Dietary Concerns (calcium, Vitamin D, etc.)
___ OTC and Natural Product Education
___ Risk Factors Education
___ 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:

_____

_____

(Continue on back if necessary)

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

_____ _____

Physician's Signature Date

Printed Name _____ UPIN# _____

Patient Name: _____ SS#: _____

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

72 Hour Notice Required for Cancellation!

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)?

What medical conditions are you being treated for?

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

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

TURN OVER >>

- 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