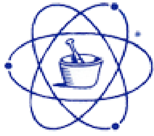 VICTORIA SQUARE COMPOUNDING PHARMACY

MEN'S HEALTH QUESTIONNARIE/PROFILE

PATIENT INFORMATION

NAME____DATE______________________________

ADDRESS ____PHONE_____________________________

CITY ______________________________PROV __________________ POSTAL CODE _____________

DATE OF BIRTH _______________________HEIGHT__________WEIGHT _______________________

BMI (Pharmacist will calculate): __________BMI=Wt. in Kg/Ht. in meters 2)

BMI RESULTS FOR ADULTS OVER 35:

19-26.9	Recommended	30-39.9	Obese
27-29.9	Overweight	40+	Morbidly Obese

MEDICAL AND SOCIAL HISTORY: Please check the following that apply to you:

__high blood pressure	__alcohol use	__high cholesterol
__erectile dysfunction	__cardiovascular disease	__insomnia
__diabetes mellitus	__malnutrition	__osteoporosis
__depression	__benign prostatic hyperplasia	__asthma/COPD
__cancer:_______________	__tobacco use	__other:_______________________

MEDICATION HISTORY: List all prescription and non prescription medications you are taking. Include vitamins, herbal, and supplements)

____

____

____

____

DRUG ALLERGIES: ____

____

____

CIRCLE YES OR NO TO THE FOLLOWING QUESTIONS. IF YES, INDICATE IF MILD, MODERATE OR SEVERE.

1) Do you feel more fatigued and or tired than usual? **Yes** **No**
If yes, circle**:** **MILD** **MODERATE** **SEVERE**

2) Have you noticed a decrease in your muscle mass? **Yes** **No**
If yes, circle**:** **MILD** **MODERATE** **SEVERE**

3) Have you experienced a loss in strength? **Yes** **No**
If yes, circle**:** **MILD** **MODERATE** **SEVERE**

4) Have you experienced an increase in joint and /or muscle pain? **Yes** **No**
If yes, circle**:** **MILD** **MODERATE** **SEVERE**

5) Have you noticed an increase in your waist size? **Yes** **No**
If yes, circle**:** **MILD** **MODERATE** **SEVERE**

6) Do you have trouble losing weight? **Yes** **No**
If yes, circle**:** **MILD** **MODERATE** **SEVERE**

7) Have you experienced loss in height? **Yes** **No**
If yes, circle**:** **MILD** **MODERATE** **SEVERE**

8) Do you have decrease in your sex drive? **Yes** **No**
If yes, circle**:** **MILD** **MODERATE** **SEVERE**

9) Have you experienced difficulty in establishing or maintaining full erections? **Yes** **No**
If yes, circle**:** **MILD** **MODERATE** **SEVERE**

10) Do you have a decrease in spontaneous early morning erections? **Yes** **No**
If yes, circle**:** **MILD** **MODERATE** **SEVERE**

11) Have you experienced changes in your usual sleep pattern? **Yes** **No**
If yes, circle**:** **MILD** **MODERATE** **SEVERE**

12) Do you feel a decrease in mental sharpness? **Yes** **No**
If yes, circle**:** **MILD** **MODERATE** **SEVERE**

13) Have you had trouble concentrating? **Yes** **No**
If yes, circle**:** **MILD** **MODERATE** **SEVERE**

14) Do you experience less enjoyment in personal hobbies and interests? **Yes** **No**
If yes, circle**:** **MILD** **MODERATE** **SEVERE**

15) I am ___________years old. I feel ____________ years old.