



CAREL' Pharmacy Compounding

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Men's Health Profile/Questionnaire

Patient Information

Name: _____ Date: _____
Address: _____ City, State: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____
Date of Birth: _____ Height: _____ Weight: _____
Age: _____ Age you Feel: _____

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

- | | |
|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Alcohol Use |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Erectile Dysfunction |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Malnutrition |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Benign Prostatic Hyperplasia | <input type="checkbox"/> Cancer: _____ |
| <input type="checkbox"/> Tobacco Use | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Asthma/COPD | |

Medication History: List all prescription and non-prescription medications that you are currently taking. (Include vitamins, herbals and supplements.)

Drug Allergies:

Symptoms:

	Absent	Mild	Moderate	Severe
Fatigue Lack of Energy	_____	_____	_____	_____
Decreased Muscle Mass	_____	_____	_____	_____
Loss of Muscle Strength	_____	_____	_____	_____
Increase in Joint/ Muscle Pain	_____	_____	_____	_____
Increase in Waist Size	_____	_____	_____	_____
Trouble Losing Weight	_____	_____	_____	_____
Loss of Height	_____	_____	_____	_____
Decrease in Sex Drive	_____	_____	_____	_____
Difficulty Establishing And/or Maintaining Full Erections	_____	_____	_____	_____
Decrease in Spontaneous Early Morning Erections	_____	_____	_____	_____
Changes in Sleep Patterns	_____	_____	_____	_____
Decrease in Mental Sharpness	_____	_____	_____	_____
Trouble Concentrating	_____	_____	_____	_____
Less Enjoyment in Personal Interests/ Hobbies	_____	_____	_____	_____
Increase in Irritability Or Worsening of Temper	_____	_____	_____	_____