Safeway Compounding Pharmacy
6100 Hellyer Avenue #100, San Jose, CA 95138
Phone (408)227-1098 * Fax (408)227-1206

PATIENT INFORMATION AND HEALTH SUMMARY

Name Date

Address

Phone Date of Birth Height Weight

Email Address (for contact purpose only)

Occupation Full Time? ☐ Part Time? ☐ Retired? ☐

Check the following symptoms as they apply to you:

Symptoms:	Rare	Mild	Frequent	Severe
1. Fatigue, tiredness, or loss of energy	☐	☐	☐	☐
2. Decrease in physical stamina	☐	☐	☐	☐
3. Feelings of depression	☐	☐	☐	☐
4. Decreased libido	☐	☐	☐	☐
5. Dry skin on face or hands	☐	☐	☐	☐
6. Increase in waist size, weight gain	☐	☐	☐	☐
7. Increased fat distribution in chest area or hips	☐	☐	☐	☐
8. Feeling burned out, loss of motivation	☐	☐	☐	☐
9. Decrease in muscle mass	☐	☐	☐	☐

Prescription and/or non-prescription meds you are taking, including vitamins, herbals, etc.

Medical Conditions you are being treated for:

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

NATURAL HORMONE REPLACEMENT CONSULTATION/ASSESSMENT INFORMATION

Do You Drink Alcohol? ☐ Y ☐ N How frequently?_____

Do You Smoke? ☐ Y ☐ N If yes, how many cigarettes per day?_____

Do You Exercise? ☐ Y ☐ N Type?_____ How often?_____

Caffeine Consumption ☐ Y ☐ N Type (coffee,soda)_____ How often?_____

Describe Your Diet:

Breakfast:

Lunch:

Dinner:

Snacks:

Do you have diabetes? ☐ Y ☐ N

Is there diabetes in your family? ☐ Y ☐ N

Do you have a current PSA level on file? ☐ Y ☐ N Results_____

Do you know your cholesterol level? ☐ Y ☐ N HDL____ LDL_____ TGs_____

NATURAL HORMONE REPLACEMENT CONSULTATION/ASSESSMENT INFORMATION

Past Medical Conditions (Check all that apply)

- ☐ Asthma
- ☐ Cancer (type _____)
- ☐ Depression
- ☐ Diabetes
- ☐ Headaches/Migraine
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ Osteoporosis/Osteopenia
- ☐ Fractures
- ☐ Epilepsy
- ☐ Liver Disorder
- ☐ Chronic Fatigue Syndrome
- ☐ Fibromyalgia
- ☐ Arthritis
- ☐ Varicose Veins
- ☐ Kidney Disorder
- ☐ Thyroid Disorder
- ☐ High Cholesterol
- ☐ Clotting Disorder
- ☐ Gallbladder Disease
- ☐ Eating Disorder
- ☐ Ulcers
- ☐ Other_____

Family History (Check all that apply)

- ☐ Cancer (Type_____)
- ☐ Diabetes (Type_____)
- ☐ Osteoporosis
- ☐ Heart Disease
- ☐ Alzheimer's Disease

STRESS RESPONSE SYSTEM QUESTIONNAIRE B

Do you frequently feel cold? ☐ Y ☐ N

Do you suffer from insomnia? ☐ Y ☐ N

Do you have low blood pressure? ☐ Y ☐ N

Do you frequently get irritable? ☐ Y ☐ N

Do you have poor memory or concentration? ☐ Y ☐ N

Do you notice palpitations? ☐ Y ☐ N

Do you get frequent/chronic infections? ☐ Y ☐ N

Do you have dry, thinning skin? ☐ Y ☐ N

Do you get headaches? ☐ Y ☐ N

Do you have unexplained hair loss? ☐ Y ☐ N

Do you skip meals? ☐ Y ☐ N

Do you exercise less than twice a week? ☐ Y ☐ N

Do you have thyroid problems? ☐ Y ☐ N

Do you lack energy during the day? ☐ Y ☐ N

Do you need caffeine in the morning or after lunch? ☐ Y ☐ N

Are you emotionally overstressed? ☐ Y ☐ N

Do you suffer from depression or down moods? ☐ Y ☐ N

Do you experience a “second wind” (high energy) at bedtime? ☐ Y ☐ N

Do you suffer from low blood sugar/hypoglycemia? ☐ Y ☐ N
(i.e. headaches, sleepiness, mood swings if skipping meals)

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RELEASE AUTHORIZATION

☐ I hereby release my Physician to furnish an agent of Safeway Compounding Pharmacy any and all records pertaining to my medical history, services rendered, and/or treatments.

☐ I authorize my Pharmacist to release my personal medication and/or other medical information to my Physician(s) upon request or as deemed necessary.

☐ I understand that employees of Safeway Compounding Pharmacy will protect my privacy and this information will be released to other health care professionals only when necessary in order to provide health care services to me. This authority shall continue until revoked by me in writing.

Physician Name (Last, First)

Phone

Physician Name (Last, First)

Phone

Physician Name (Last, First)

Phone

Patient Name:

Address

City, State, Zip

Phone

Email

Signature Date