Male Customized Hormone Replacement Therapy Evaluation

Figure 4. Steroidogenesis pathways

Customized Medication Compounding (USP 795) • Medication Therapy Management Botanical and Nutraceutical Medicines • Sterile Products Laboratory (USP 797)
Proud Compounding Pharmacy of the Cleveland Indians
Suggested Lab Work for Men

Blood or saliva levels of hormones can be helpful in evaluating your replacement needs. We suggest that you have your physician get a base-line level of your hormones before starting human bio-identical hormone replacement. Although it is not absolutely necessary to have this information for your physician and the pharmacist to complete your evaluation, it is often helpful. The lab tests may consist of drawing up to 8 vials of blood, and may be expensive if you do not have insurance. There are also saliva labs that may be drawn, but may not be covered by your insurance. You may want to discuss this with your physician prior to starting your therapy. The suggested ICD-10 may be any of the following: E34.9 – Endocrine disorder, unspecified; E29.1 – Testicular hypofunction; N52.9 – Male erectile dysfunction, unspecified; E27.8 – Other specified disorders of the adrenal gland.

The following labs are what we suggest you have drawn. If not all are affordable, please let us know and we will suggest which labs would be best to draw based on your completed evaluation.

![Laboratory Blood Tests](image)

These labs should be drawn in the morning between 7:00-9:00, fasting, before taking your morning medications and supplements.

Your physician may also want to draw thyroid labs. Suggested ICD-10 E03.8 – Other specified hypothyroidism. If they do, we suggest the following complete panel:
TSH, T3 Total, T3 Free, T4 Total, T4 Free, Reverse T3, thyroglobulin, thyroglobulin antibody, thyroid peroxidase antibody, ferritin and serum serotonin.

Consider fasting insulin, glucose, hemoglobin A1C, and C-peptide labs if you suspect Metabolic Syndrome or other blood sugar imbalances. Other cardiovascular labs such as a cholesterol panel, C-reactive protein, homocysteine and Lipoprotein (a) may also be helpful. Suggested ICD10 – E78.2 Mixed hyperlipidemia.
Buderer Drug offers an ongoing consultation service for patients who are receiving customized hormone replacement therapy. A one-time consulting fee of $65.00 will be charged to you when you start customized hormone replacement therapy. This fee covers all services you receive with our expert pharmacists, including: initial work-up, consultations with you and your physician, continuing follow-up of your progress, and future therapy modification consultations with your physician. This one-time fee is all you’ll pay so long as Buderer Drug maintains your hormone replacement prescription. We will provide you with a medical receipt for insurance purposes. Please be advised that your insurance may or may not pay for some or all of your prescription and consultation. Any charges not covered by your insurance will be your responsibility. We look forward to serving and caring for you.

Effective 8-05
Natural Hormone Replacement Confidential Evaluation

From a clinical management point of view, it is very useful to gain a detailed history of possible hormone deficiencies. The answers provided to questions in this form will allow us to maintain your medical history and will help in advising about current medical therapies. All information provided will be kept confidential. The pharmacist will evaluate this form. When complete, please give the form, as well as any lab work to the pharmacist or the physician or nurse practitioner and have it faxed to the pharmacy. Please call the pharmacy to schedule a phone or face-to-face appointment.

GENERAL INFORMATION

Name: ___________________________________ Age: _____ Birthdate: ________________

Address: _______________________________________________________________________

City, State Zip: ___________________________________________________________________

Home Phone: ____________________ Work Phone: ____________________ FAX: ________________

Occupation: ________________________ Full-Time: ___ Part-Time: ___ Retired: ___ Unemployed: ___ Other: ___

Living Situation: Spouse: ___ Alone: ___ Partner: ___ Friend(s): ___ Parents: ___ Children: ___ Other: ___


Pets: __________________________________ Indoors?: ____________ Bedroom: ______________________

How did you hear about Natural Hormone Replacement Therapy?


Other: __________________________________________________________

Who referred you to us? ____________________________________________

Do you understand what Natural Hormone Replacement is? ________________________________

What is your greatest need or problem today? (List the most important; then list four other issues in order of importance):

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________
INSURANCE and PHYSICIAN INFORMATION

We will be glad to assist you in filling out your insurance claim forms if we are not able to transmit your prescription on-line. Payment is due in full at the time services are rendered.

Your SS#: ______________________

Prescription Insurance Company: _________________________________________________________________

Cardholder's Name: _______________________ Birthdate: ______________________

Is address same as yours?  Y  N  If no, give Cardholder's Full Address and Telephone: ______________________

Employer: ____________________ Cardholder's SS#: ____________________ Sex: Male  Female

Cardholder's ID#: ____________________ Prescription Plan #: ____________________ Group #: ________

Your relationship to Cardholder: Self  Spouse  Other: ____________ Miscellaneous: ______________________

Which Health Care Provider (physician, midwife, etc.) should we contact concerning this consult?

_________________________________________________________________________________________

When was your last appointment with this Health Care Provider? ________________________________

Other Current and Recent Health Care Providers: ________________________________________________
MEDICAL STATUS

How do you rate your general health?  Excellent; Good; Fair; Poor. Height: ___ft. ___in.; Weight: ______ lbs.

Blood Type: ________________ Blood Pressure: _____________ Pulse: ______

Your current medical conditions or diagnoses: __________________________________________________________
_________________________________________________________________________________________________

Drug Allergies: _____________________________________________________________________________________
_________________________________________________________________________________________________

Allergies to Food, Pollens, Environment, etc: ________________________________________________________________________________________________
_________________________________________________________________________________________________

Names of ALL Prescription Medications, taken in last 6 months. Include strength and how you take them:
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________

Have you taken any Dietary Supplements: Dihydroepiandrosterone (DHEA), Creatine Phosphate, Anabolic Steroids, Androstenedione, etc.:  Y  N

Names of products: __________________________________________________________________________________
_________________________________________________________________________________________________

Names of ALL Vitamins, Herbal Products, Non-Prescription medicines, or other OTC products that you are currently using:
_________________________________________________________________________________________________
_________________________________________________________________________________________________

Are you currently taking medication for a thyroid condition?  Y  N  Which one and Dose? ______________________

How many times has your thyroid dosage been adjusted in the last year? _____  If you know your most current lab work, enter it here:  TSH _____ T4 _____ T3 uptake _____ T7 _____ rT3 _____ TBG _____ Thyroid Autoantibody _____

Have your blood lipid (cholesterol/triglyceride) levels been checked recently?  Y  N  When? _____________ Results: Cholesterol (TC) ______ Triglycerides _____ HDLC ______ LDL ______ VLDL ______ Chol/HDL ______

How often are your bowel movements: _____/day OR _____/week. Do you suffer from frequent constipation, irritable bowel, colitis, diarrhea or frequent bowel movements? Please give details: ________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
Please close the ring finger and thumb of one hand around your other wrist. Do the ring finger and thumb touch? Y N

Have you ever had a bone density scan? Y N When? __________; Results: ____________________________

Do you use tobacco products? Y N What: __________; How Much: __________; For How Long: __________


Do you use caffeine products? Y N What: __________; How Much: __________

Do you use recreational drugs? Y N What: __________; How Much: __________

How much water do you drink in one day (24 hr)? __________ oz. __________ glasses

Is your drinking water from a:____ home well  ____ city water  ____ distilled water  ____ bottled water  ____ water purifier  ____________________________

Dietary Restrictions (such as salt, carbohydrates, milk products, red meat, etc): ____________________________

Please list your Typical Food Choices:

Breakfast: ____________________________________________________________

Lunch: __________________________________________________________________________________

Dinner: _____________________________________________________________________________________

Snacks: _____________________________________________________________________________________

________________________________________

Please circle applicable Food Cravings: None  Sweets  Salts  Chocolate  Other: ____________________________

Do you get routine Physical Exercise? IF YES, then what type?

How long per day? _____ minutes/day and/or _____ hours/day; How many days per week: ____ days.

What is your average heart rate when you are exercising? _________

SLEEP: How long does it take you to fall asleep? Minutes: 5 10 15 30 60+ How many hours of sleep do you get per night? _______ hours  Do you sleep uninterrupted all night? Y N If No, how many times do you awaken? _______ times. Do you awaken at a particular time(s)? _____________ What awakens you? ____________

Do you dream? Y N If Yes, do you remember your dreams? Y N

Do you nap during the day? Y N How often and how long do you nap? ________________________________
PAST MEDICAL CONDITIONS

List your Childhood Diseases: _________________________________________________________________________
___________________________________________________________________________________________________
_______________________________________________________________________________________________

PERSONAL & FAMILY HISTORY: (you, your parents, brothers, sisters, and grandparents. Please list whom in the details section)

- Alzheimer's Disease? Y Details _______________________________________________________
- Asthma? Y Details _______________________________________________________
- Anemia? Y Details _______________________________________________________
- Eating Disorder? Y Details _______________________________________________________
- Depression? Y Details _______________________________________________________
- Headaches? Y Details _______________________________________________________
- Epilepsy? Y Details _______________________________________________________
- Dry, Coarse Skin Y Details _______________________________________________________
- Prematurely Gray? Y N Who/When _______________________________________________
- Thyroid Problem? Y Details _______________________________________________________
- Osteoporosis? Y Details _______________________________________________________
- Fractures (broken bones)? Y Details _______________________________________________________
- Arthritis? Rheumatoid Osteo Y Details _______________________________________________________
- Diabetes? IDDM NIDDM Y Details _______________________________________________________
- Lupus? Y Details _______________________________________________________
- Kidney Disease? Y Details _______________________________________________________
- Pancreas Disease? Y Details _______________________________________________________
- Fibromyalgia? Y Details _______________________________________________________
- Chronic Fatigue Syndrome? Y Details _______________________________________________________
- Mitral Valve Prolapse? Y Details _______________________________________________________
- Heart Trouble? Y Details _______________________________________________________
- High Blood Pressure? Y Details _______________________________________________________
- Stroke? Y Details _______________________________________________________
- Blood Clotting Disorder? Y Details _______________________________________________________
- Varicose Veins? Y Details _______________________________________________________
- High Cholesterol? Y Details _______________________________________________________
- High Triglycerides? Y Details _______________________________________________________
- Gall Bladder Trouble? Y Details _______________________________________________________
- Liver Disease or Hepatitis? Y Details _______________________________________________________
- Irritable Bowel or Colitis? Y Details _______________________________________________________
- Decreased Vision, Blindness or Retinal Problem Y Details _______________________________________________________
- Sexually Transmitted Diseases? Y Details _______________________________________________________
- Benign Prostatic Hyperplasia (BPH)? Y Details _______________________________________________________
- Abnormal Prostate Enlargement? Y Details _______________________________________________________
- Polyps? Y Details _______________________________________________________
- Breast Cancer? Y Details _______________________________________________________
- Prostate Cancer? Y Details _______________________________________________________
- Cancer (any other type) Y Details _______________________________________________________

Page 5 of 12
UROLOGICAL

When was your last: General medical exam: ___________________ Prostate exam: _______________________

Have you ever had Abnormal Prostate Enlargement? Y  N  When? _______ Treatment: _______________________

Have you been diagnosed with Benign Prostatic Hyperplasia (BPH)? Y  N  When? _______________________

Treatment: _______________________

Have you ever had Problems with Urinary Tract Infections (UTI)? Y  N  When? _______________________

Treatment: _______________________

Have you ever had Kidney Infections? Y  N  When? __________ Treatment: _______________________

Are you currently having any difficulty urinating? Y  N

If Yes, Describe: ________________________________________________________________

Any recent unusual penis discharge or itching: Y  N  Describe: _______________________________________

Are you currently having any changes/problems not listed previously? Y  N

If Yes, Describe: ________________________________________________________________

Have you had any of the following surgeries:

Vasectomy? Y  N  When? ___________________ and at what age? _______________________

Prostate removed (prostatectomy)? Y  N  When? _______ Why? _______________________

Testicles removed (castration)? Y  N  When? _______ Why? _______________________

Any other type of surgery? Y  N  What type? ___________________ When/Why? _______________________

Were there any problems associated with the surgery or removal of any of these organs? Y  N

If Yes, Describe: ________________________________________________________________

Have you ever been diagnosed with Breast Cancer? Y  N  When? _________ Treatment? _______________________

Have you ever been diagnosed with Prostate Cancer? Y  N  When? _________ Treatment? _______________________

Has your doctor ordered any lab tests or diagnostic procedures for you recently? Y  N  Did you have the diagnostic procedure or lab performed? Y  N  Please give details: ________________________________________________________________
SEXUAL

Are you sexually active now?  Y  N  If No, is that a problem for you?

If you were rating the sexual part of your life on a scale of 1 to 10, where would you put it? (10 = most satisfied)

1  2  3  4  5  6  7  8  9  10

What would you change about it, if you could?

Do you have any problems with sexual:

Desire? __________________________________________________________

Frequency? _________________________________________________________

Arousalability? _____________________________________________________

Have you ever had Erection or Potency Problems?  Y  N  Describe: ______________________________________________________________

Have you ever had Ejaculation Problems?  Y  N  Describe: ________________________________________________________________

Have you ever had Loss of Early Morning Erection?  Y  N

Have you ever had Pain During Intercourse?  Y  N

  If Yes, where and how long? __________________________________________

  When does the pain happen: at the beginning of, during, or after having sex? _________________________________________________

Have you noticed any changes in your Body Hair Patterns?  Y  N  Describe: _____________________________________________________

Have you lost any pubic hair?  Y  N  If Yes, when did you first notice it? _______________________________________________________

Has your sex life changed significantly in the past few years?  Y  N

  If Yes, how? ______________________________________________________

Do you think there is anything your partner would like to change?  Y  N

  If Yes, describe? __________________________________________________

Is there anything you can think of that we have not covered and that may be important to your sexual life?  Y  N

  If Yes, describe? __________________________________________________

______________________________________________________________________________

Page 7 of 12
CIRCLE A NUMBER FOR EACH SYMPTOM which best describes how you have been feeling for the past 3 weeks.

0 = None (symptom not present)  
1 = Mild (present but not distressing)  
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3 = Severe (very distressing, interferes with daily life)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Trend</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Your Comments</th>
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<tr>
<td>Hot flushes</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
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<td>Night Sweats</td>
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<td>0</td>
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<td>3</td>
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<td>Light-headed Feelings/Dizziness</td>
<td></td>
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<td>2</td>
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<td></td>
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<tr>
<td>Headaches</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
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<tr>
<td>Sleep Disorders/Sleeplessness</td>
<td></td>
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<td>2</td>
<td>3</td>
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<td>Unusual Tiredness/Fatigue</td>
<td></td>
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<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
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<td>Irritability</td>
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<td>Depression</td>
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<td>2</td>
<td>3</td>
<td></td>
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<tr>
<td>Unloved Feelings</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
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<tr>
<td>Anxiety/Tension/Nervousness</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
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<tr>
<td>Mood Swings/Mood Changes</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Crying Easily</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
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<tr>
<td>Angry Outbursts/Arguments/ Violent Tendencies</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
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<tr>
<td>Backache</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Joint Pains</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Muscle Pains</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Decrease in Muscle Mass</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>
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<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
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</thead>
<tbody>
<tr>
<td>Dry Skin/Dry Hair</td>
<td></td>
<td>0</td>
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<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Crawling Feeling Under Skin</td>
<td></td>
<td>0</td>
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<td>2</td>
<td>3</td>
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<tr>
<td>Frequent Urinary tract infection/prostate infection</td>
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<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Urinary frequency/incontinence</td>
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<td>2</td>
<td>3</td>
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<tr>
<td>Abnormal Penis Discharge</td>
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<td>2</td>
<td>3</td>
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<tr>
<td>Erection/Potency Problems</td>
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<td>0</td>
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<td>2</td>
<td>3</td>
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<td>Ejaculation Problems</td>
<td></td>
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<tr>
<td>Uncomfortable intercourse</td>
<td></td>
<td>0</td>
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<td>2</td>
<td>3</td>
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<tr>
<td>Loss of Sexual Feeling/Desire</td>
<td></td>
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<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Loss of Arousability</td>
<td></td>
<td>0</td>
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<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Loss of Early Morning Erection</td>
<td></td>
<td>0</td>
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<td>2</td>
<td>3</td>
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<tr>
<td>Loss of Pubic Hair</td>
<td></td>
<td>0</td>
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<td>2</td>
<td>3</td>
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<tr>
<td>Any Recent Change in Body Hair Patterns</td>
<td></td>
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<td>2</td>
<td>3</td>
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<tr>
<td>Forgetfulness/Short Term Memory Loss</td>
<td></td>
<td>0</td>
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<td>2</td>
<td>3</td>
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<tr>
<td>Confusion/Difficulty Concentrating</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>Heart Palpitations</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>Shortness of Breath</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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</tbody>
</table>
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<tr>
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<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Your Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Tenderness</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>→</td>
</tr>
<tr>
<td>Swelling of Hands, Ankles, or Breast</td>
<td>----</td>
<td>0</td>
<td>----</td>
<td>1</td>
<td>----</td>
</tr>
<tr>
<td>Food Cravings /Sweets / Salts</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>→</td>
</tr>
<tr>
<td>Increased appetite/Weight Gain</td>
<td>----</td>
<td>0</td>
<td>----</td>
<td>1</td>
<td>----</td>
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<tr>
<td>Loss of Vital Energy (Vitality)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>→</td>
</tr>
<tr>
<td>Acne/Pimples/Skin Flushing</td>
<td>----</td>
<td>0</td>
<td>----</td>
<td>1</td>
<td>----</td>
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<tr>
<td>Tightness in neck/shoulders</td>
<td>----</td>
<td>0</td>
<td>----</td>
<td>1</td>
<td>----</td>
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<tr>
<td>Visual Disturbance or Decreased Vision</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>→</td>
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<tr>
<td>Difficulty Hearing</td>
<td>----</td>
<td>0</td>
<td>----</td>
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<td>----</td>
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<tr>
<td>Diminished sense of taste</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>→</td>
</tr>
<tr>
<td>Diminished sense of smell</td>
<td>----</td>
<td>0</td>
<td>----</td>
<td>1</td>
<td>----</td>
</tr>
<tr>
<td>Problems with wound healing time</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>→</td>
</tr>
<tr>
<td>Muscle cramps/spasms</td>
<td>----</td>
<td>0</td>
<td>----</td>
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**TEMPERATURE LOG**

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<tr>
<th>ENTER DATE &gt;</th>
<th>TAKE YOUR TEMPERATURES AT:</th>
<th>LOCATION TO TAKE AT:</th>
<th>ON FIRST DAY</th>
<th>ON SECOND DAY</th>
<th>ON THIRD DAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Awaking (within 10 minutes)</td>
<td>Under Tongue</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Mid-day</td>
<td>Under Tongue</td>
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<tr>
<td>3. Evening</td>
<td>Under Tongue</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Bedtime</td>
<td>Under Tongue</td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

This log will help determine your basal temperature and your average daily temperature. Since we want to do the best job possible in optimizing our health recommendations for you, it is important that you obtain the most accurate temperature readings possible by carefully following the temperature-taking procedure outlined below:

**PROCEDURE:**

1. Use any thermometer available but note the type used. Be sure to "sling" the mercury down to 96° F. prior to using the old type thermometers.

2. Sling the mercury down each night before going to bed, if you have this kind.

3. In the morning, as soon as you wake up, put the thermometer under your tongue, then record the temperature in the proper space on the chart. Do this before you get out of bed, have anything to eat, drink, or engage in any activity.

4. Take the next 3 temperatures during the day.

5. Record the temperatures on lines 1 through 4 of the Temperature Log chart provided above.
   - Be sure to record the exact temperature, including the tenth of a degree even if it is an even number.
   - Example: 97.2°, 98.0°, etc.

What type of thermometer did you use? ________________________________________________________________
Patient Consult from Buderer Drug Co.

Name: ___________________________ DOB: _____________ Date: ______________

Place your signature here: ______________________________________________________

Please note: If you should have any questions concerning the suggested therapy for this patient, please contact our
compounding pharmacist. If you should concur with some or all of these suggested therapies, please indicate which ones and
then sign this sheet and fax it back to our lab. Only with your authorization will we put up the prescriptions for this patient.

Buderer Drug Co. fax:   □ Perrysburg (419) 873-0494   □ Sandusky (419) 626-0494   □ Avon (440) 934-3103

I approve of the recommendations made and the evaluation of my patient in this consult.

CPT (99202) Evaluation. Related ICD-10: □ E34.9 – Endocrine disorder, unspecified; □ N95.1 – Menopausal and female
climacteric states; □ E29.1 – Testicular hypofunction; □ N52.9 – Male erectile dysfunction, unspecified; □ E27.8 – Other
specified disorders of the adrenal gland; □ E03.8 – Other specified hypothyroidism; □ E78.2 Mixed hyperlipidemia