MALE CUSTOMIZED HORMONE REPLACEMENT THERAPY EVALUATION

Figure 4. Steroidogenesis pathways.
**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.

Additional Labs:

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
Consultant Pharmacist Agreement for New Patients

Starting Customized Hormone Replacement Therapy

Buderer Drug offers an ongoing consultation service for patients who are receiving customized hormone replacement therapy. A one-time consulting fee of $95.00 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 1-1-2022
# 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

<table>
<thead>
<tr>
<th>Name:</th>
<th>Age:</th>
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<thead>
<tr>
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<thead>
<tr>
<th>Home Phone:</th>
<th>Work Phone:</th>
<th>FAX:</th>
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<th>Occupation:</th>
<th>Full-Time:</th>
<th>Part-Time:</th>
<th>Retired:</th>
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<th>Spouse:</th>
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<th>Partner:</th>
<th>Friend(s):</th>
<th>Parents:</th>
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<th>Pets:</th>
<th>Indoors?:</th>
<th>Bedroom?:</th>
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</table>

How did you hear about Natural Hormone Replacement Therapy?

- Ad: __
- Another Patient: __
- Courses/Seminars: __
- Physician/Healthcare practitioner: __
- Books/Articles: __
- 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/HDLC _______

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 alcohol 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)

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<thead>
<tr>
<th>Condition</th>
<th>Y</th>
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<td>Anemia?</td>
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<td>Eating Disorder?</td>
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<td>Depression?</td>
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<td>Headaches?</td>
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<td>Epilepsy?</td>
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<tr>
<td>Dry, Coarse Skin</td>
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<tr>
<td>Prematurely Gray?</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>Thyroid Problem?</td>
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<td>Osteoporosis?</td>
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<td>Fractures (broken bones)?</td>
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<td>Kidney Disease?</td>
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<td>Pancreas Disease?</td>
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<td>Fibromyalgia?</td>
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<td>Chronic Fatigue Syndrome?</td>
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<td>Mitral Valve Prolapse?</td>
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<td>Heart Trouble?</td>
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<td>High Blood Pressure?</td>
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<td>Stroke?</td>
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<td>Blood Clotting Disorder?</td>
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<td>Varicose Veins?</td>
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<td>High Cholesterol?</td>
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<td>High Triglycerides?</td>
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<td>Gall Bladder Trouble?</td>
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<td>Liver Disease or Hepatitis?</td>
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<td>Irritable Bowel or Colitis?</td>
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<td>Decreased Vision, Blindness or Retinal Problem</td>
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<tr>
<td>Sexually Transmitted Diseases?</td>
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<tr>
<td>Benign Prostatic Hyperplasia (BPH)?</td>
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<td></td>
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<tr>
<td>Abnormal Prostate Enlargement?</td>
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<tr>
<td>Polyps?</td>
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<tr>
<td>Breast Cancer?</td>
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<tr>
<td>Prostate Cancer?</td>
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<tr>
<td>Cancer (any other type)</td>
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</tbody>
</table>
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: ________________________________

______________________________________________________________________________________________________
______________________________________________________________________________________________________
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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?  ______________________________________________________________

Arousability?  ______________________________________________________________

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?  ______________________________________________________________

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<tr>
<th>Symptom</th>
<th>Trend</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
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<td>2</td>
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<td>Sleep Disorders/Sleeplessness</td>
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<td>Depression</td>
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<tr>
<td>Unloved Feelings</td>
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<td>Mood Swings/Mood Changes</td>
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<td>Crying Easily</td>
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<td>3</td>
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<td>Angry Outbursts/Arguments/ Violent Tendencies</td>
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<td>Joint Pains</td>
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<td>Muscle Pains</td>
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<td>2</td>
<td>3</td>
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<tr>
<td>Decrease in Muscle Mass</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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</table>
CIRCLE A NUMBER FOR EACH SYMPTOM which best describes how you have been feeling for the past 3 weeks.

0 = None (symptom not present)       2 = Moderate (distressing, but not interfering with daily life)
1 = Mild (present but not distressing) 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>Dry Skin/Dry Hair</td>
<td></td>
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<td>2</td>
<td>3</td>
<td></td>
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<tr>
<td>Crawling Feeling Under Skin</td>
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<td>3</td>
<td></td>
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<tr>
<td>Frequent Urinary tract infection/prostate infection</td>
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<td>Urinary frequency/incontinence</td>
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<td>Abnormal Penis Discharge</td>
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<td>Erection/Potency Problems</td>
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<td>Ejaculation Problems</td>
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<td>Uncomfortable intercourse</td>
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<td>Loss of Sexual Feeling/Desire</td>
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<td>Loss of Arousability</td>
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<tr>
<td>Loss of Early Morning Erection</td>
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<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Loss of Pubic Hair</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Any Recent Change in Body Hair Patterns</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Forgetfulness/Short Term Memory Loss</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Confusion/Difficulty Concentrating</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Heart Palpitations</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Shortness of Breath</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>
CIRCLE A NUMBER FOR EACH SYMPTOM which best describes how you have been feeling for the past 3 weeks.

<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>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Tenderness</td>
<td></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>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>3 →</td>
</tr>
<tr>
<td>Food Cravings /Sweets / Salts</td>
<td></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>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>3 →</td>
</tr>
<tr>
<td>Loss of Vital Energy (Vitality)</td>
<td></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>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>3 →</td>
</tr>
<tr>
<td>Tightness in neck/shoulders</td>
<td></td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>3 →</td>
</tr>
<tr>
<td>Visual Disturbance or Decreased Vision</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Difficulty Hearing</td>
<td></td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>3 →</td>
</tr>
<tr>
<td>Diminished sense of taste</td>
<td></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>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>3 →</td>
</tr>
<tr>
<td>Problems with wound healing time</td>
<td></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>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>3 →</td>
</tr>
</tbody>
</table>
**TEMPERATURE LOG**

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

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