Confidential Female Hormone Evaluation

Pharmacy Solutions
5750 Hidcote Dr. Lincoln, NE 68516
Toll Free: 888.890.6521
Fax: 402.486.4286
402.486.3383

Evaluation must be returned at least two days prior to your consult or you may be asked to reschedule your appointment!!

From a clinical management point of view, it is very useful to gain a detailed history of possible hormone deficiencies. The answers provided in the questions below will allow the pharmacist to maintain your medical history and will help in advising about current medical therapies. All information provided will be kept confidential.

Medical History

Name: _____ Birth date: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ _____ E-mail Address: _____
(primary) (secondary) (optional)

Height: _____ Weight: _____

Your occupation:_____

Practitioner(s) currently seeing:
Name: Address: Phone:
_____
_____
_____

How did you arrive at the decision to consider BHRT?

□Doctor □Self □Friend/Family member □Other

Who Referred You?:
_____

Current Medical Conditions:
_____
_____
_____

Allergies: Please check all that apply

___ Penicillin	___ morphine	___ dye allergies	___ pet allergies
___ Codeine	___ aspirin	___ nitrate allergy	___ seasonal allergies
___ sulfa drug	___ food allergies	___ no known allergies	other: _____

Please describe the allergic reaction you experienced and when it occurred.

_____

_____

Over the counter (OTC) medications:
Please check all products that you use occasionally or regularly. Check all that apply.

___ Pain reliever
___ Aspirin
___ Acetaminophen (example Tylenol®)
___ Ibuprofen (example Motrin®, Advil®)
___ Naproxen (example Aleve®)
___ Ketoprofen (example Orudis KT®)
___ Cough Suppressant (example Robitussin DM®)
___ Antihistamine product (Benedryl®)
___ Decongestant product (Sudafed®)
___ Sleep aids
___ Anti-diarrheals
___ Laxatives
___ Diet Aids/Weight Loss products
___ Antacids
___ Acid blockers
___ Other (please list)
_____
_____

Nutritional/Natural Supplements: Please list the products you are using

Vitamins: _____
Minerals: _____
Herbs: _____
Enzymes: _____
Nutritional/Protein Supplements: _____
Others: _____

Current Prescription Medications (Star the Medications that have been added within the last 6 months):
Medication name Strength Date started How often per day

_____

_____

_____

_____

_____

_____

List Hormones previously taken
Hormone Date Started/Date Stopped→Reason

_____

_____

_____

Does anybody else in your household use hormones? □Yes □No

Have you ever used oral contraceptives? □Yes □No

Current form of birth control_____

Any problems? □Yes □No
If **YES**, describe any
problem(s)_____

Habits:

Dietary restrictions: _____

Meal Choices: Breakfast: _____
Lunch: _____
Dinner: _____

			How often and how much?
Do you use tobacco?	☐Yes	☐No	_____
Do you use alcohol?	☐Yes	☐No	_____
Do you use caffeine?	☐Yes	☐No	_____

How many ounces of water do you drink a day? _____

			What type and how often?
Do you get regular exercise?	☐Yes	☐No	_____

How often do you have a bowel movement? _____

Are you fearful of anything? _____

Rank your stress level on a typical day (0-none, 1-mild, 2-moderate, 3-severe) _____
List any major stressors or stressful events in the last 3 to 5 years_____

Medical conditions/diseases: Please check all that apply to you.

Heart Disease		High Blood Pressure		Chronic Fatigue	
Stroke		High Cholesterol		Eating Disorder	
Clotting Defect		Diabetes		Thyroid Disease	
Kidney Trouble		Epilepsy		Headaches	
Fractures		Arthritis		Cancer	
Colitis		Gallbladder Trouble		Varicose Veins	
Irritable Bowel		Asthma		Depression	
Ulcers		Autoimmune Disorder		Eye Disease	
Fibromyalgia		Osteoporosis		Others: please list below	

Age your mother went into menopause: _____ Age your sister(s) went through menopause:_____

When was your last period? _____ How many days did it last? _____

What is your average cycle length_____ Breakthrough Bleeding?_____

(i.e. 26 days, 28 days)
Explain typical cycle (i.e. clotting, dark discharge, heavy/light flow)_____
Any bleeding between periods?:_____ When: _____

Do you Ovulate Y or N? Please explain._____

Fertility issues past or present? Please explain._____

How many pregnancies have you had? _____ How many children? ____ Ages of children_____

Any problems with your pregnancies? _____
_____

Any interrupted pregnancies? ☐Yes ☐No Explain: _____
_____
_____

Are you or have you suffered from postpartum depression Y or N? Please explain_____
_____

Have you had a hysterectomy? ☐Yes ☐No Date _____ Age_____

Ovaries removed? ☐Yes ☐No

Have you had a tubal ligation? ☐Yes ☐No Date _____

Do you have a family history of any of the following?

Uterine Cancer _____ Family member(s) _____
Ovarian Cancer _____ Family member(s) _____
Colon Cancer _____ Family member(s) _____
Fibrocystic Breast _____ Family member(s) _____
Breast Cancer _____ Family member(s) _____
Heart Disease_____ Family member(s) _____
Osteoporosis _____ Family member(s) _____
Thyroid _____ Family member(s) _____
Autoimmune _____ Family member(s) _____
Other _____ Family member(s) _____

Have you had any of the following tests performed? Check those that apply and note the date

Mammography	☐Yes	☐No	Date: _____
Pap Smear	☐Yes	☐No	Date: _____
Bone Density	☐Yes	☐No	Date: _____
Thyroid tested	☐Yes	☐No	Date: _____

Have any of these test results been abnormal? If YES, please explain:_____
_____
_____

List any surgeries you have had and approximate date(s):_____
_____
_____

Since you first began having a period, have you ever had what YOU would consider to be an abnormal cycle?

☐Yes ☐No

If YES, please explain (such as the approximate date, age when this occurred, and the symptoms experienced)

_____

_____

Do you have, or did you ever have Premenstrual Syndrome (PMS)? ☐Yes ☐No

If YES, explain symptoms: _____

_____

Examine breasts monthly: ☐Yes ☐No

Ever experienced breast pain, discomfort, etc.: ☐Yes ☐No

Ever been diagnosed with lumps, fibroids, breast cancer, etc.: ☐Yes ☐No

What are your goals with taking Bio-Identical Hormone Replacement Therapy?

_____

_____

_____

_____

Do you understand the concept of Bio-Identical Hormone Replacement Therapy? _____

Please write down any questions you have about Bio-Identical Hormone Replacement Therapy?

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Symptoms

Rate your current status for each symptom by checking the appropriate modifier. Please feel free to use additional space to describe any symptoms. This section may be repeated upon subsequent visits.

Today's Date _____

***If you mark YES, please rank mild, moderate or severe**

SYMPTOM	Yes or No	1-Mild	2-Moderate	3-Severe
Fibrocystic Breast				
Nipple Sensitivity				
Breast Tenderness				
Heavy/Irregular Menses				
Breakthrough Bleeding				
Abnormal Bleeding				
Cramps				
Pelvic Pain				
Pelvic Pressure				
Pelvic Fullness				
Fluid Retention/Bloating				
Vaginal Dryness				
Bladder Symptoms				
Urinary Frequency				
Frequent Urinary Tract Infection (UTI)				
Harder to Reach Climax				
Decreased Sex Drive				
Uncomfortable Intercourse				
Loss of Vitality				

SYMPTOM	Yes or No	1-Mild	2-Moderate	3-Severe
New Facial Hair				
Dry Skin/Hair				
Weight Gain/Increased Appetite				
Food/Sweets/Salt Cravings				
Fluid Retention				
Hot Flashes				
Night Sweats				
Headaches				
Backaches				
Joint Pains				
Muscle Pains				
Arthritis				
Heart Palpitations				
Crawling Feeling Under Skin				
Swelling of Hands				
Swelling of Ankles				
Swelling of Breasts				
Tightness in Neck/Shoulders				
Depression				
Confusion/Difficulty Concentrating				

SYMPTOM	**Yes or No**	**1-Mild**	**2-Moderate**	**3-Severe**
Anxiety				
Mood Swings				
Crying Easily				
Angry Outbursts/Arguments/ Violent Tendencies				
Fatigue				
Loss of Memory				
Diminished Sense of Taste				
Decreased Vision				
Difficulty Falling Asleep				
Difficulty Staying Asleep				