Female 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 in the questions below will allow the pharmacist to maintain your medical history and will help in advising about current medical therapies for hormone replacement. All information provided will be kept confidential.

General Information

Today's Date:____________

Name: ________________________________ Age:_______ Birth Date:____________

Full Address, City, Zip:____

Home Ph:____________________ Work Ph:______________ Cell Ph:_________________
Please put a star next to your preferred contact phone number.
e-mail Address:____

Occupation:__________________ Full time _____ Part Time _____ Retired _____ Unemployed ____ Other _____

Living Situation: Spouse _____ Alone _____ Partner _____ Friends _____ Parents _____ Children _____ Other _____

How did you hear about Bio-Identical Hormone Replacement Therapy? Ad ___ Another Patient _______

Courses/Seminar____ Physician/Healthcare Practitioner _____Books/Articles_____ Other______

Who referred you to Pacific Compounding Pharmacy?_________________________________

Do you understand what Bio-Identical Hormone Replacement Therapy is?__________________

What are your goals for Bio-Identical Hormone Replacement Therapy?____________________

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Current Doctor or Nurse: ______________________________If Kaiser: MR#________________

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Medical Status

General Health: Excellent _____ Good _____ Fair _____ Poor _____ Weight: _____ Height: _____

Current diagnosis or medical conditions: ____

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Allergies: Please check all that apply

- ❑ Penicillin
- ❑ Codeine
- ❑ Morphine
- ❑ Aspirin
- ❑ Sulfa drugs
- ❑ Dyes
- ❑ Nitrates
- ❑ Pets
- ❑ Pollens
- ❑ Seasonal
- ❑ Foods ___________________________
- ❑ Other ___________________________

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Medication History **please bring all medications and natural products to your appointment**

Medication Name **Strength** **How often per day** **Date Started**

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List Hormones you have previously taken

Medication Name **Strength** **Date started** **Date Stopped** **Reason**

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Over The Counter products:

- ❑ Pain Reliever
- ❑ Aspirin
- ❑ Acetaminophen (Tylenol®)
- ❑ Ibuprofen (Motrin IB®)
- ❑ Naproxen (Aleve®)
- ❑ Cough Suppressant (Robitussin DM®)
- ❑ Antihistamine (Chlor-Trimeton®, Zyrtec®)
- ❑ Decongestant (Sudafed®)
- ❑ Sleep Aid (Unisom®, Tylenol PM®)
- ❑ Antidiarrheal (Imodium®)
- ❑ Laxative/Stool Softener (Correctol®, Colace®)
- ❑ Diet aid/Weight Loss (Dexatrim®)
- ❑ Antacids (Maalox®, Mylanta®, TUMS®)
- ❑ Acid Blocker (Pepcid®, Zantac®, Prilosec®)
- ❑ Other ______________________________

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Nutritional/natural products:

- ❑ Vitamins ____
- ❑ Minerals ____
- ❑ Herbs ____
- ❑ Enzymes ____
- ❑ Nutrition/Protein Supplements ______________________________
- ❑ Other ____

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Past Medical Conditions

❑ Acne	❑ Clotting Defects	❑ Gallbladder Issues	❑ Stroke
❑ Arthritis	❑ Diabetes	❑ Heart Disease	❑ Thyroid Issues
❑ Asthma	❑ Eating Disorder	❑ High Blood Pressure	❑ Other___________
❑ Cancer	❑ Epilepsy	❑ Kidney Disease	_________________
❑ Cholesterol Issues	❑ Fibromyalgia	❑ Liver Trouble	_________________
❑ Chronic Fatigue	❑ Fractures	❑ Migraines	_________________

Family History

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

Alzheimer's	____________	Family Member(s)	______________________________
Breast Cancer	____________	Family Member(s)	______________________________
Diabetes	____________	Family Member(s)	______________________________
Fibrocystic Breasts	____________	Family Member(s)	______________________________
Ovarian Cancer	____________	Family Member(s)	______________________________
Uterine Cancer	____________	Family Member(s)	______________________________
Heart Disease	____________	Family Member(s)	______________________________
Osteoporosis	____________	Family Member(s)	______________________________
Clotting Disorder	____________	Family Member(s)	______________________________

Laboratory Reports *Have you had the following Tests performed?* *Please bring results*

Cholesterol	Yes ❑ No ❑	Date______________	Results:____________________________
Thyroid	Yes ❑ No ❑	Date______________	Results:____________________________
Mammogram	Yes ❑ No ❑	Date______________	Results:____________________________
PAP Smear	Yes ❑ No ❑	Date______________	Results:____________________________
Bone density	Yes ❑ No ❑	Date______________	Results:____________________________
Blood pressure	Yes ❑ No ❑	Date______________	Results:____________________________

Habits

Typical Diet/Meal Plan:____

Please list typical intake: Breakfast:______________________________________

Lunch ______________________________________

Dinner______________________________________

How much water do you drink in a day? _______________________________

How often and how much?

Do you get physical exercise? Yes ❑ No ❑ ____________________________

Do you use tobacco products? Yes ❑ No ❑ ____________________________

Do you use alcohol products? Yes ❑ No ❑ ____________________________

Do you use caffeine products? Yes ❑ No ❑ ____________________________

Stress Level: High _____ Moderate _______ Low ______

General causes/duration of stress: ______________________________________

Obstetrical History

Are you sexually active? Yes ❑ No ❑ Are you trying to get pregnant? Yes ❑ No ❑

Have you ever used contraceptives? Yes ❑ No ❑ What kind?____________________

Any problems? Yes ❑ No ❑

If yes, describe:____

____

Age at first pregnancy ______ Number of pregnancies? _____ Did you feel good pregnant? Y N

# of deliveries?______________ How old are your children? ____ ____ ____ ____ ____ ____

Any interrupted pregnancies? (miscarriages or abortions) Yes ❑ No ❑ How far along?____________

Have you had a tubal ligation? Yes ❑ No ❑ Has your partner had a vasectomy? Yes ❑ No ❑

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Gynecological History

Age at first period:_____________________ Date of last period:___________________________

Have you ever had an abnormal PAP? Yes ❑ No ❑ If yes, treatment:______________________

Do you have, or did you ever have Premenstural Syndrome (PMS)? Yes ❑ No ❑

If yes, explain symptoms:____

____

How many days from start of one period to the start of the next?_______________Days of flow?______

Amount of cramps: Extreme ❑ Moderate ❑ Mild ❑ None ❑

Any current changes in your normal cycle? Yes ❑ No ❑

If yes, describe:____

____

Any bleeding between periods? Yes ❑ No ❑ If yes, when? ________________________

Any pelvic pain, pressure or fullness? Yes ❑ No ❑ Describe:__________________________

Any unusual vaginal discharge or itching? Yes ❑ No ❑ Describe:__________________________

Have you had a hysterectomy? Yes ❑ No ❑ Date: ____________________________

Reason for hysterectomy: ____

Have you had your ovaries removed?Yes ❑ No ❑ Date: ____________________________

Reason for oopherectomy: ____

Do you have Poly Cystic Ovary Disease? Yes ❑ No ❑ Date of diagnosis______________________

Symptoms I

For Symptoms I, II, and III: Have you experienced any of the following symptoms recently? Please circle the number that best describes *your* experiences using the following scale-
1 = absent/not a problem, 5 = moderate, 10 = severe.

	ABSENT				MODERATE					SEVERE
Hot flashes (____/day)	1	2	3	4	5	6	7	8	9	10
Night sweats (____/night)	1	2	3	4	5	6	7	8	9	10
Shortness of breath	1	2	3	4	5	6	7	8	9	10
Irregular menses	1	2	3	4	5	6	7	8	9	10
Headaches	1	2	3	4	5	6	7	8	9	10
Mood swings	1	2	3	4	5	6	7	8	9	10
Depression	1	2	3	4	5	6	7	8	9	10
Anxiety	1	2	3	4	5	6	7	8	9	10
Short term memory loss	1	2	3	4	5	6	7	8	9	10
Sleep disorders, insomnia	1	2	3	4	5	6	7	8	9	10
Time to bed:					Time to wake:					
Do you fall asleep quickly?					How often do you wake?					
Vaginal dryness	1	2	3	4	5	6	7	8	9	10
Vaginal shrinking	1	2	3	4	5	6	7	8	9	10
Painful intercourse	1	2	3	4	5	6	7	8	9	10
Inability to reach orgasm	1	2	3	4	5	6	7	8	9	10
Frequent urinary tract infections	1	2	3	4	5	6	7	8	9	10
Frequent yeast infections	1	2	3	4	5	6	7	8	9	10
Dry hair	1	2	3	4	5	6	7	8	9	10
Hair loss	1	2	3	4	5	6	7	8	9	10
Dry skin	1	2	3	4	5	6	7	8	9	10
Heart palpitations	1	2	3	4	5	6	7	8	9	10
Muscle or joint pain	1	2	3	4	5	6	7	8	9	10

Symptoms II

Symptoms II	ABSENT				MODERATE					SEVERE
Fuzzy thinking	1	2	3	4	5	6	7	8	9	10
Inability to concentrate	1	2	3	4	5	6	7	8	9	10
Depression	1	2	3	4	5	6	7	8	9	10
Emotional swings	1	2	3	4	5	6	7	8	9	10
Irritability	1	2	3	4	5	6	7	8	9	10
Food cravings	1	2	3	4	5	6	7	8	9	10
Heavy menses	1	2	3	4	5	6	7	8	9	10
Uterine fibroids	1	2	3	4	5	6	7	8	9	10
Fibrocystic breasts	1	2	3	4	5	6	7	8	9	10
Swollen breasts	1	2	3	4	5	6	7	8	9	10
Painful breasts	1	2	3	4	5	6	7	8	9	10
Bloating	1	2	3	4	5	6	7	8	9	10
Water retention	1	2	3	4	5	6	7	8	9	10
Weight gain (how much?___)	1	2	3	4	5	6	7	8	9	10
Cramps	1	2	3	4	5	6	7	8	9	10

Symptoms II

Symptoms II	ABSENT				MODERATE					SEVERE
Fatigue	1	2	3	4	5	6	7	8	9	10
Best time of day:				Worst time of day:						
Lack of energy	1	2	3	4	5	6	7	8	9	10
Loss of sex drive	1	2	3	4	5	6	7	8	9	10
Inability to concentrate	1	2	3	4	5	6	7	8	9	10
Vocal changes	1	2	3	4	5	6	7	8	9	10
Increased facial hair	1	2	3	4	5	6	7	8	9	10
Enlarged clitoris	1	2	3	4	5	6	7	8	9	10
Acne/Roseacea	1	2	3	4	5	6	7	8	9	10

Symptoms IV

	ABSENT				MODERATE					SEVERE
Constipation	1	2	3	4	5	6	7	8	9	10
Brittle nails	1	2	3	4	5	6	7	8	9	10
Nighttime urination	1	2	3	4	5	6	7	8	9	10
Increased hunger	1	2	3	4	5	6	7	8	9	10
Increased thirst	1	2	3	4	5	6	7	8	9	10
Dry eyes	1	2	3	4	5	6	7	8	9	10
Rapid aging	1	2	3	4	5	6	7	8	9	10
Change in height	1	2	3	4	5	6	7	8	9	10
Cold hands and feet	1	2	3	4	5	6	7	8	9	10

Patient questions or concerns

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Patient Name:________________________________