Custom Prescription Shoppe
1543 15th Street
Augusta, GA 30901
Phone: 706-737-3955
Fax: 706-737-6323

Custom Pharmacy
1202 Town Park Lane, Ste. 101
Evans, GA 30809
Phone: 706-760- 7956
Fax: 706-993-3772

Custom Pharmacy of NA
401 West Martintown Rd, Ste. 153
North Augusta, SC 29841
Phone: 803-693-5514
Fax: 803-792-9066

Medical History Form

Today's Date: _______________

1. Patient Information

Patient Name: ____DOB:_________________________

Address: ____________________________________City: ________________State:________ Zip: ___________

Phone: _____________________________ Email: ____

2. Lifestyle information

	Do you use? Yes or no	If YES how often and how much
Tobacco (smoke, chew, dip, vape)		
Alcohol (beer, wine, liquor)		
Caffeine (cola drinks, tea, coffee)		

Impairments: Check if you have any of the following:

_____Physical Impairment _____Visual Impairment ______Hearing Impairment

Exercise: Do you exercise regularly? ______Yes ______No

If Yes describe what you do and how often:

Stress Management: Do you practice any stress management techniques? _____Yes ______No

If Yes describe what you do and how often:

Diet: Describe your typical daily food intake:

1st Meal 2nd Meal 3rd Meal Snacks

3. Doctor Information: Are you currently under the care of a physician? ______Yes _______No

If YES, Please list each doctor from whom you seek care, including address/location and phone number, if known

Name____________________________ Address_________________________ Phone__________________

Name____________________________ Address_________________________ Phone__________________

Name____________________________ Address_________________________ Phone__________________

Patient signature:____ Date:_______________

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4. Allergies: Please check all that apply:

__ Penicillin
__ Codeine
__ Sulfa drug
__ Morphine
__ Aspirin
__ Food allergies
__ Dye allergies
__ Nitrate
__ No known
__ Pet allergies
__ Seasonal (Pollen)
Other: ___________

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

5. Over the counter (OTC) issues:

Please check all products that you use at home occasionally or regularly. Check all that apply.

__ Pain reliever
__ Aspirin
__ Acetaminophen (Tylenol®)
__ Ibuprofen (Motrin®)
__ Naproxen (Aleve®)
__ Cough Suppressant (Ex: Robitussin®)
__ Antihistamine (Ex: Benadryl®, Zyrtec®)
__ Decongestant (Ex: Sudafed®)
__ Sleep Aid (Ex: Nyquil®)
__ Combination product (cough+cold, Robitussin DM®)
__ Antidiarrheal (Ex: Imodium®)
__ Laxatives (Ex: Colace®, Miralax®, Senokot®)
__ Diet Aid/Weight Loss Supplement
__ Antacids (Ex: Maalox®, Tums®)
__ Acid Blockers (Ex: Pepcid, Zantac, Prilosec, Nexium)
__ Other (Please list below)
____
____

__ Nutritional/Natural Supplements (Ex: Vitamins, Minerals, Herbs, Workout Supplements)

Supplement Name	Dose/Frequency

6. Medical Conditions. Please Check all that apply to you.

__ Heart Disease (Ex: Heart Failure)
__ High Cholesterol
__ High Blood Pressure
__ Cancer
__ Ulcers (GERD, Gastric)
__ Thyroid Disorders
__ Hormone Imbalances
__Blood Clotting Disorders
__ Eye Disorders (Ex: Glaucoma)
__ Lung Condition (Ex: Asthma, COPD, Emphysema)
__ Diabetes
__ Arthritis or other joint issues
__ Depression or other mood disorders
__ Epilepsy or other seizure disorders
__ Headaches/migraines
__ Other (Please list below)
____
____

7. Prescription Medications:

Medication Name	Dose/Frequency	Prescribing Physician

Patient signature:____ Date:_______________

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Hormone Replacement Therapy Specific Information

1. How did you arrive at the decision to consider Prescription Bio-Identical Hormone Restoration?
   a. ______Doctor ______Self ______ Friend/Family Member

2. Bone Size ______ Small ______Medium ______ Large

3. Body Type ______Apple ______Pear ______ Hourglass ______ Athletic

4. Have you ever used oral contraceptives? ______Yes ______No
   a. If YES any problems? ______Yes ______No

5. How many pregnancies have you had?______ How many children?______

6. Have you had a hysterectomy? ______Yes ______No
   a. If YES, date of surgery:_________ ______Total ______Uterus only

7. Have you had a tubal ligation? ______Yes ______No

8. Do you have a family history or any of the following? Check all that apply:

   ______Uterine Cancer ______Ovarian Cancer ______ Breast Cancer
   ______Heart Disease ______ Osteoporosis

9. Were you prematurely gray? ______Yes ______No

10. Please list the date of the last following exams:
    Mammogram: ________________ Pap Smear: ________________

11. Since you first began having periods, have you ever had what YOU would consider to be abnormal cycles? ______Yes ______No
    a. If YES, please explain (such as age when this occurred, what happened, etc.)

    ____

12. When was your last period? ________________ How many days did it last?________________

13. Have you ever had Premenstrual Syndrome (PMS)? ______Yes ______No
    a. If YES, explain symptoms: ____
    ____

Patient signature:____ Date:________________

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Hormone Replacement Therapy Patient Information Sheet

Have you experienced any of the following symptoms recently? Please circle the number that best describes your experiences, with **1 being Extremely Mild** and **10 being Extremely Severe**.

Symptom										
Sleep Disruptions	1	2	3	4	5	6	7	8	9	10
Fatigue	1	2	3	4	5	6	7	8	9	10
Vaginal Dryness	1	2	3	4	5	6	7	8	9	10
Irritability	1	2	3	4	5	6	7	8	9	10
Nervousness	1	2	3	4	5	6	7	8	9	10
Breast Tenderness	1	2	3	4	5	6	7	8	9	10
Hot Flashes	1	2	3	4	5	6	7	8	9	10
Dry Skin	1	2	3	4	5	6	7	8	9	10
Mood Swings	1	2	3	4	5	6	7	8	9	10
Arthritis	1	2	3	4	5	6	7	8	9	10
Loss of Recent Memory	1	2	3	4	5	6	7	8	9	10
Weight Gain	1	2	3	4	5	6	7	8	9	10
Decreased Sex Drive	1	2	3	4	5	6	7	8	9	10
Depression	1	2	3	4	5	6	7	8	9	10
Fluid Retention	1	2	3	4	5	6	7	8	9	10
Headaches	1	2	3	4	5	6	7	8	9	10
Night Sweats	1	2	3	4	5	6	7	8	9	10
Hair Loss	1	2	3	4	5	6	7	8	9	10
Harder to Reach Climax	1	2	3	4	5	6	7	8	9	10
Bladder Symptoms	1	2	3	4	5	6	7	8	9	10

Patient signature:____ Date:_______________

Symptoms List

The following score sheet will help you to determine whether hormone testing is needed, and which tests to order. Each category is divided into hormone deficiency and excess, as each has a different subset of symptoms. Score the symptoms which apply to you as **O (none), 1 (mild), 2 (moderate), or 3 (severe).** A score of 10 or higher in any one category (deficiency and excess combined) is probably worthwhile to test.

Estrogen(Estradiol)

Estrogen Deficiency

- ___ Hot Flashes
- ___ Night sweats
- ___ Vaginal dryness
- ___ Foggy thinking
- ___ Memory lapses
- ___ Incontinence
- ___ Tearful
- ___ Depressed
- ___ Sleep disturbances
- ___ Heart palpitation
- ___ Bone loss

Estrogen Excess

- ___ Mood Swings (PMS)
- ___ Tenderbreasts
- ___ Water retention
- ___ Nervous
- ___ Irritable
- ___ Anxious
- ___ Fibrocystic breasts
- ___ Uterine fibroids
- ___ Weight gain in hips
- ___ Bleeding changes
- ___ Headaches

Progesterone

Progesterone Deficiency

- ___ Hot Flashes
- ___ Night sweats
- ___ Vaginal dryness
- ___ Foggy thinking
- ___ Memory lapses
- ___ Incontinence
- ___ Tearful
- ___ Depressed
- ___ Sleep Disturbances
- ___ Heart palpitation
- ___ Bone loss

Progesterone Excess

- ___ Sleepiness
- ___ Breast swelling/tenderness
- ___ Decreased libido
- ___ Mild depression
- ____ Candida infections

Androgens (DHEA and Testosterone)

Androgen Deficiency

- ___ Low libido
- ___ Vaginal dryness
- ___ Foggy thinking
- ___ Fatigue
- ___ Aches/pains
- ___ Memory !apes
- ___ Incontinence
- ___ Depressed
- ___ Sleep Disturbances
- Bone loss
- ___ Decreased muscle mass
- ___ Thinning skin

Androgen Excess

- ___ Excessive facial/body hair
- ___ Loss of scalp hair
- ___ Increased acne
- ___ Oily skin

Cortisol

Cortisol Deficiency

- ___ Fatigue
- ___ Sugar craving
- ___ Allergies
- ___ Chemical sensitivity
- ___ Stress
- ___ Cold body temperature
- ___ Heart palpitations
- ___ Aches/pains
- ___ Arthritis

Cortisol Excess

- ___ Sleep disturbances
- ___ Bone loss
- ___ Fatigue
- ___ Weight gain in waist
- ___ Loss of muscle mass
- ___ Thinning skin

Patient signature:____ Date:______________