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?____________________

____

____

____

Current Doctor or Nurse: ______________________________ If Kaiser: MR#____________

Medical Status

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

Current diagnosis or medical conditions: ______________________________________

____

Allergies: Please check all that apply

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

____

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

Medication Name	Strength	How often per day	Date Started

List Hormones you have previously taken

Medication Name	Strength	Date started	Date Stopped	Reason

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 _____

Nutritional/natural products:

- ❑ Vitamins _____
- ❑ Minerals _____
- ❑ Herbs _____
- ❑ Enzymes _____
- ❑ Nutrition/Protein Supplements _____
- ❑ Other _____

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?

Alzheimers	_____	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 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 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?_____ Deliveries?_____

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 ❑

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:					
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 pain/weakness	1	2	3	4	5	6	7	8	9	10
Joint pain	1	2	3	4	5	6	7	8	9	10

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	1	2	3	4	5	6	7	8	9	10
Cramps	1	2	3	4	5	6	7	8	9	10

Symptoms II

	ABSENT					MODERATE				SEVERE
Fatigue	1	2	3	4	5	6	7	8	9	10
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
High blood pressure	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

Patient questions or concerns