



Patient signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History Form**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**1. Patient Information**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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

4. Allergies: Please check all that apply:

 \_\_ Penicillin \_\_ Morphine \_\_ Dye allergies \_\_ Pet allergies

 \_\_ Codeine \_\_ Aspirin \_\_ Nitrate \_\_ Seasonal (Pollen)

 \_\_ Sulfa drug \_\_ Food allergies \_\_ No known 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 \_\_ Combination product (cough+cold, Robitussin DM®)

 \_\_ Aspirin \_\_ Antidiarrheal (Ex: Imodium®)

 \_\_ Acetaminophen (Tylenol®) \_\_ Laxatives (Ex: Colace®, Miralax®, Senokot®)

 \_\_ Ibuprofen (Motrin®) \_\_ Diet Aid/Weight Loss Supplement

 \_\_ Naproxen (Aleve®) \_\_ Antacids (Ex: Maalox®, Tums®)

 \_\_ Cough Suppressant (Ex: Robitussin®) \_\_ Acid Blockers (Ex: Pepcid, Zantac, Prilosec, Nexium)

 \_\_ Antihistamine (Ex: Benadryl®, Zyrtec®) \_\_ Other (Please list below)

 \_\_ Decongestant (Ex: Sudafed®) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_ Sleep Aid (Ex: Nyquil®) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_ 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) \_\_ Lung Condition (Ex: Asthma, COPD, Emphysema)

 \_\_ High Cholesterol \_\_ Diabetes

 \_\_ High Blood Pressure \_\_ Arthritis or other joint issues

 \_\_ Cancer \_\_ Depression or other mood disorders

 \_\_ Ulcers (GERD, Gastric) \_\_ Epilepsy or other seizure disorders

 \_\_ Thyroid Disorders \_\_ Headaches/migraines

 \_\_ Hormone Imbalances \_\_ Other (Please list below)

 \_\_Blood Clotting Disorders \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_ Eye Disorders (Ex: Glaucoma) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Prescription Medications:

|  |  |  |
| --- | --- | --- |
| Medication Name | Dose/Frequency | Prescribing Physician |
|  |  |  |
|  |  |  |
|  |  |  |

Patient signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. How did you arrive at the decision to consider Prescription Bio-Identical Hormone Restoration?
	1. \_\_\_\_\_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
	1. If YES any problems? \_\_\_\_\_Yes \_\_\_\_\_No
5. How many pregnancies have you had? \_\_\_\_\_ How many children? \_\_\_\_\_
6. Have you had a hysterectomy? \_\_\_\_\_Yes \_\_\_\_\_No
	1. 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

1. Were you prematurely gray? \_\_\_\_\_Yes \_\_\_\_\_No
2. Please list the date of the last following exams:

Mammogram: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pap Smear: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Since you first began having periods, have you ever had what YOU would consider to be abnormal cycles? \_\_\_\_\_Yes \_\_\_\_\_No
	1. If YES, please explain (such as age when this occurred, what happened, etc.)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. When was your last period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many days did it last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Have you ever had Premenstrual Syndrome (PMS)? \_\_\_\_\_Yes \_\_\_\_\_No
	1. If YES, explain symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hormone Replacement Therapy Specific Information

Patient signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient signature: Date:

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

Other: 1 2 3 4 5 6 7 8 9 10

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**.

Hormone Replacement Therapy Patient Information Sheet

|  |
| --- |
|  **Estrogen**(Estradiol)**Estrogen Deficiency** **Estrogen Excess** Hot Flashes Mood Swings (PMS) Night sweats \_ Tender breasts Vaginal dryness Water retention Foggy thinking Nervous Memory lapses Irritable Incontinence Anxious Tearful Fibrocystic breasts Depressed Uterine fibroids Sleep disturbances Weight gain in hips Heart palpitation Bleeding changes Bone loss Headaches |
| **Progesterone****Progesterone Deficiency** Heart palpitation Hot Flashes Bone loss Night sweats Vaginal dryness Foggy thinking **Progesterone Excess** Memory lapses Sleepiness Incontinence Breast swelling/tenderness Tearful Decreased libido Depressed Mild depression Sleep Disturbances Candida infections |
| **Androgens (DHEA and Testosterone**)**Androgen Deficiency** Bone loss Low libido Decreased muscle mass Vaginal dryness Thinning skin Foggy thinking Fatigue **Androgen Excess** Aches/pains Excessive facial/body hair Memory !apes Loss of scalp hair Incontinence Increased acne Depressed Oily skin Sleep Disturbances |
| **Cortisol****Cortisol Deficiency** Arthritis Fatigue Sugar craving **Cortisol Excess** Allergies Sleep disturbances Chemical sensitivity Bone loss Stress Fatigue Cold body temperature Weight gain in waist Heart palpitations Loss of muscle mass Aches/pains Thinning skin |

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**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.