

Confidential Female Hormone Evaluation

Pharmacy Solutions
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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: _____ (primary) _____ (secondary) E-mail Address: _____ (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.

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

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				