Confidential Female Hormone Evaluation

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*To allow enough time to review evaluation, please return at least **two days** prior to your consultation.*

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: __________________ __________________ E-Mail Address: __________________
(primary) (secondary)

Height: ____________ Weight: _____________

Your Occupation: ____

Practitioner(s) currently seeing:
Name: Address: Phone:

____

____

____

How did you arrive at the decision to consider Bio-Identical Hormone Replacement Therapy (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.

____ Pain reliever
____ Aspirin
____ Acetaminophen (example Tylenol®)
____ Ibuprofen (example Motrin®, Advil®)
____ Naproxen (example Aleve®)
____ Ketoprofen (example Orudic KT®)
____ Cough Suppressant (example Robitussin DM®)
____ Antihistamine product (example Benadryl®)
____ Decongestant product (example Sudafed®)

____ Sleep aids
____ Anti-Diarrheals
____ Laxatives
____ Diet Aids/Weight Loss Products
____ Antacids
____ Acid Blockers
____ Other (please list)
____
____

Nutritional/Natural Supplements: Please list the products you are using

Vitamins: ______________________________
Minerals: ______________________________
Herbs: ______________________________
Enzymes: ______________________________
Nutritional/Protein Supplements: ______________________________
Other: ______________________________

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/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 with your current birth control? ☐ Yes ☐ No

If YES, describe any problem(s) ______________________________

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___

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? ☐ Yes ☐ No Please explain: ____

Fertility issues past or present? ☐ Yes ☐ No Please explain: ___________________________________

How many pregnancies have you had? _______ How many children? ______ Ages of children ______________

Any problems with your pregnancies? ____

Any interrupted pregnancies? ☐ Yes ☐ No

Please explain ____

____

____

Are you suffering/Have you suffered from postpartum depression? ☐ Yes ☐ No

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 Disorder_______ 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 (i.e. the approximate date, age when this occurred, and symptoms experienced)

____

____

Do you have, or did you ever have Premenstrual Syndrome (PMS)? ☐ Yes ☐ No
If YES, please explain symptoms: ____

____

Examine breasts monthly? ☐ Yes ☐ No

Ever experience 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?

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Do you understand the concept of Bio-Identical Hormone Replacement Therapy? _________________________

Please write down any questions you have about Bio-Identical Hormone Replacement Therapy.

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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				

SYMPTOM	Yes or No	1 – Mild	2 – Moderate	3 - Severe
Bladder Symptoms				
Urinary Frequency				
Frequent Urinary Tract Infections (UTIs)				
Harder to Reach Climax				
Decreased Sex Drive				
Uncomfortable Intercourse				
Loss of Vitality				
New Facial Hair				
Dry Skin/Hair				
Weight Gain/Increased Appetite				
Food/Sweets/Salt Cravings				
Fluid Retention				
Hot Flashes				
Night Sweats				
Headaches				

SYMPTOM	Yes or No	1 – Mild	2 – Moderate	3 - Severe
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				
Anxiety				
Mood Swings				

SYMPTOM	Yes or No	1 – Mild	2 – Moderate	3 - Severe
Crying Easily				
Angry Outbursts/Arguments or Violent Tendencies				
Fatigue				
Loss of Memory				
Diminished Sense of Taste				
Decreased Vision				
Difficulty Falling Asleep				
Difficulty Staying Asleep				