PHARMACY RX CONFIDENTIAL HORMONE EVALUATION
MEDICAL HISTORY

DATE: _____

Name: _____ **Social Sec #:** _____

Address: _____ **Birthdate:** _____ **Age:** _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **E-mail Address:** _____

Alt Phone: _____ **Height:** _____ **Weight:** _____

Gender: ☐ **Male** ☐ **Female**

Do you use tobacco? ☐ Yes ☐ No Frequency _____ Quantity _____

Do you use alcohol? ☐ Yes ☐ No Frequency _____ Quantity _____

Do you use caffeine? ☐ Yes ☐ No Frequency _____ Quantity _____

Doctor's Name: **Address:** **Phone:**

_____

_____

_____

Allergies: Please check all that apply.

☐ Penicillin ☐ Morphine ☐ Dye Allergies ☐ Pet Allergies

☐ Codeine ☐ Aspirin ☐ Nitrate Allergy ☐ Seasonal (pollen) Allergies

☐ Sulfa Drug ☐ Food Allergies ☐ No Known Allergies ☐ Other:_____

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

_____

_____

_____

Over-the-counter (OTC) issues:

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

☐ Pain Reliever

☐ Aspirin

☐ Acetaminophen (Ex: Tylenol®)

☐ Ibuprofen (Ex: Motrin IB®)

☐ Naproxen (Ex: Aleve®)

☐ Ketoprofen (Ex: Orudis KT®)

☐ Cough Suppressant (Ex: Robitussin DM®)

☐ Antihistamine (Ex: Chlor-Trimeton®)

☐ Decongestant (Ex: Sudafed®)

☐ Combination product (cough + cold reliever)(ex: Triaminic DM®)

☐ Sleep Aids (ex: Excedrin PC®, Unisom®, Sominex®, Nytol®)

☐ Anti-diarrheas (Ex: Imodium®, Pepto Bismol®, Kaopectate®)

☐ Laxatives/stool softeners (Ex: Doxidan®, Correctol®, etc.)

☐ Diet aids/weight loss products (Ex: Dexatril®)

☐ Antacids (Ex: Maalox® Mylanta®)

☐ Acid Blockers (Ex: Tagamet HB®, Pepcid C®, Zantac 75®)

☐ Other (Please List) _____

_____

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

- ☐ Vitamins (Ex: multiple or single such as B complex, E, C, beta carotene)
- ☐ Minerals (Ex: calcium, magnesium, chromium, colloidal minerals, various single minerals)
- ☐ Herbs (Ex: ginseng, ginkgo biloba, echinacea, herbal medicinal teas, tinctures, remedies, etc.)
- ☐ Enzymes (Ex: digestive formulas, papaya, bromelain, coenzyme, Q10, etc.)
- ☐ Nutrition/Protein Supplements (Ex: shark cartilage, protein powers, amino acids, fish oils, etc.)
- ☐ Other: Please list:_____

Current Vitamins, Minerals, Herbs, Enzymes, Supplements:

Product Name	Strength	Type	Quantity & Times Per Day

Medical Conditions/Diseases: Please check all that apply to you.

☐ Heart Disease (Ex: Congestive Heart Failure)	☐ Blood Clotting Problems	☐ Cancer
☐ High Cholesterol or Lipids (Ex: Hyperlipidemia)	☐ Arthritis or Joint Problems	☐ Depression
☐ High Blood Pressure (Ex: Hypertension)	☐ Thyroid Disease	☐ Epilepsy
☐ Lung Condition (Ex: Asthma, Emphysema, COPD)	☐ Headaches/Migraines	☐ Eye Disease (Glaucoma, etc)
☐ Ulcers (Stomach, Esophagus)	☐ Hormone Related Issues	

☐ Other: Please list:_____

Current Prescription Medications:

Medication Name	Strength	Date Started	Times Per Day

List any hormones previously taken:

Hormone Name	Date Started	Date Stopped	Reason

Bone Size: ☐ Small ☐ Medium ☐ Large **Body Type:** ☐ Androgenic ☐ Estrogenic

Have you ever used oral contraceptives: ☐ No ☐ Yes

If any problems, please describe:_____

PATIENT NAME:_____

How many pregnancies have you had? _____ **How many children?** _____

Any interrupted pregnancies: ☐ No ☐ Yes

Have you had a hysterectomy? ☐ No ☐ Yes If yes, date of surgery:_____

Ovaries removed: ☐ No ☐ Yes

Have you had a tubal ligation? ☐ No ☐ Yes If yes, date:_____

Do you have a family history of any of the following:

Uterine Cancer	☐ No	☐ Yes	Family member(s)_____
Rheumatoid Arthritis	☐ No	☐ Yes	Family member(s)_____
Diabetes	☐ No	☐ Yes	Family member(s)_____
High Cholesterol	☐ No	☐ Yes	Family member(s)_____
Ovarian Cancer	☐ No	☐ Yes	Family member(s)_____
Fibercystic Breast	☐ No	☐ Yes	Family member(s)_____
Breast Cancer	☐ No	☐ Yes	Family member(s)_____
Heart Disease	☐ No	☐ Yes	Family member(s)_____
Lung Disease	☐ No	☐ Yes	Family member(s)_____
Eye Disease	☐ No	☐ Yes	Family member(s)_____
Ulcers	☐ No	☐ Yes	Family member(s)_____
Depression	☐ No	☐ Yes	Family member(s)_____
Headaches/Migraines	☐ No	☐ Yes	Family member(s)_____
Epilepsy	☐ No	☐ Yes	Family member(s)_____
Hormone Issues	☐ No	☐ Yes	Family member(s)_____
Osteoporosis	☐ No	☐ Yes	Family member(s)_____
Thyroid Disease	☐ No	☐ Yes	Family member(s)_____
Autoimmune Disease	☐ No	☐ Yes	Family member(s)_____

List any others_____

Have you had any of the following tests performed: Check all that apply and list date.

Mammography	☐ No	☐ Yes	Date:_____
PAP Smear	☐ No	☐ Yes	Date:_____

Since you first began having periods, have you ever had what YOU would consider to be abnormal cycles? ☐ No ☐ Yes

If YES, please explain (such as age when this occurred, symptoms, etc.):

_____

_____

_____

When was your last period? Date:_____ **How many days did it last?** _____

Do you have, or have you ever had, Premenstrual Syndrome (PMS)? ☐ No ☐ Yes

If YES, please explain (such as age when this occurred, symptoms, etc.):

_____

_____

_____

PATIENT NAME:_____

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

☐ Doctor ☐ Self ☐ Friend/Family Member ☐ Other

What are your goals with taking BHRT?

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

PATIENT NAME:_____

HORMONAL SYMPTOMS

Fibrocystic Breast	☐ Absent	☐ Mild	☐ Moderate	☐ Severe
Weight Gain	☐ Absent	☐ Mild	☐ Moderate	☐ Severe
Heavy/Irregular Menses	☐ Absent	☐ Mild	☐ Moderate	☐ Severe
Hot Flashes	☐ Absent	☐ Mild	☐ Moderate	☐ Severe
Dry Skin/Hair	☐ Absent	☐ Mild	☐ Moderate	☐ Severe
Anxiety	☐ Absent	☐ Mild	☐ Moderate	☐ Severe
Depression	☐ Absent	☐ Mild	☐ Moderate	☐ Severe
Night Sweats	☐ Absent	☐ Mild	☐ Moderate	☐ Severe
Vaginal Dryness	☐ Absent	☐ Mild	☐ Moderate	☐ Severe
Headaches	☐ Absent	☐ Mild	☐ Moderate	☐ Severe
Irritability	☐ Absent	☐ Mild	☐ Moderate	☐ Severe
Mood Swings	☐ Absent	☐ Mild	☐ Moderate	☐ Severe
Breast Tenderness	☐ Absent	☐ Mild	☐ Moderate	☐ Severe
Sleep Disturbances/Insomnia	☐ Absent	☐ Mild	☐ Moderate	☐ Severe
Cramps	☐ Absent	☐ Mild	☐ Moderate	☐ Severe
Fluid Retention	☐ Absent	☐ Mild	☐ Moderate	☐ Severe
Break-through Bleeding	☐ Absent	☐ Mild	☐ Moderate	☐ Severe
Fatigue	☐ Absent	☐ Mild	☐ Moderate	☐ Severe
Loss of Memory	☐ Absent	☐ Mild	☐ Moderate	☐ Severe
Bladder Symptoms	☐ Absent	☐ Mild	☐ Moderate	☐ Severe
Arthritis	☐ Absent	☐ Mild	☐ Moderate	☐ Severe
Harder to Reach Climax	☐ Absent	☐ Mild	☐ Moderate	☐ Severe
Decreased Sex Drive	☐ Absent	☐ Mild	☐ Moderate	☐ Severe
Hair Loss	☐ Absent	☐ Mild	☐ Moderate	☐ Severe

PATIENT NAME:_____

SYMPTOMS FREQUENCY

Please rate the frequency of your symptoms (0 = Never, 1 = Rarely, 10 = daily) to all that apply. Duplicates are intended.

PATIENT NAME:_____ **DATE:**_____

( ) Weakness
( ) Fatigue or Reduced Energy
( ) Dizziness when Standing
( ) Fainting Spells
( ) Salt Cravings
( ) Sweet Cravings
( ) Increased Fatigue after Exercise
( ) Palpitations (especially before falling asleep)
( ) Breathing Difficulties, Gasping for breath or Frequent Sighing
( ) Asthma
( ) Chest Pressure or Heaviness
( ) Depression or Sadness
( ) Anxiety
( ) Panic Attacks
( ) Poor Memory
( ) Poor Concentration
( ) Periods of Confusion
( ) Allergies
( ) Autoimmune Disorder
( ) Heat Intolerance
( ) Weight Loss
( ) Hypoglycemic Symptoms
( ) Insomnia
( ) Dry or Thin Skin
( ) Thinning Hair on Scalp
( ) Neck or Shoulder Tenderness
( ) Low Blood Pressure
( ) Difficulty waking in the Morning (more alert after 10 or 11 a.m.)
( ) Increase Fatigue after Stress
( ) Muscle or Joint Pain
( ) Burn easily in the sun
( ) Pigmented or Pale Skin

( ) Colitis or Other Stomach Issues
( ) Medication Intolerance
( ) Dry Elbows and/or Knees

( ) Frequently Cold, especially hands & feet
( ) Low Energy
( ) Post-nasal Drip or Sinus Infections
( ) Yeast Infections (including Jock Itch, Nail Fungus)
( ) Menstrual Abnormalities
( ) Endometriosis, PCOS, Fibroid Tumors
( ) Headaches and/or Migraines
( ) Infertility
( ) Miscarriages
( ) Difficult or Long Labor/Delivery
( ) PMS
( ) Joint Pain
( ) Loss of Motivation
( ) Difficulty learning new information
( ) ADD or ADHD
( ) Concentration Difficulties
( ) Feeling Blue or Depressed
( ) Unusual or Frequent Fears
( ) Unable to Sleep
( ) Wanting to Sleep All the Time
( ) Goiter
( ) Eyebrows thin
( ) Morning Stiffness
( ) Indigestion
( ) Constipation
( ) Diarrhea
( ) Irritable Bowel Syndrome
( ) Restless Leg Syndrome
( ) Muscle or Leg Cramps
( ) Acne
( ) Brittle, peeling or breaking nails
( ) Thin and/or Brittle Hair

( ) Psoriasis
( ) Low Temperatures
( ) Weight Gain

( ) Poor Muscle Tone
( ) Muscle Pains
( ) Joint Pains
( ) Loss of Interest in Life
( ) Low Energy
( ) Periods of Weakness
( ) Declining Memory
( ) Tremors
( ) Rheumatoid Arthritis
( ) Chronic Fatigue Syndrome
( ) AIDS
( ) Chemical Sensitivities
( ) Lupus Erythematosis
( ) Obesity
( ) Cardiovascular Disorders
( ) Osteoporosis
( ) Alzheimer's Disease
( ) Diabetes
( ) Signs of Aging
( ) Decreased Immunity
( ) Decreased Memory
( ) Decreased Quality of Sleep
( ) Dry Hair
( ) Dry Skin
( ) Sparse Body Hair
( ) Loss of Pubic or Underarm Hair

( ) Chronic Fatigue Syndrome
( ) Dehydration
( ) Absent Mindedness
( ) Difficulty Focusing
( ) Frequent Urination