

Hormone Health & Wellness 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. All information provided will be kept confidential.

GENERAL INFORMATION

Date: _____

Name: _____ Age: _____ Birth Date: _____

Street Address _____ Apt. _____

City: _____ State _____ Zip: _____

Driver's License or Social Security Number (Please circle): _____

Occupation: _____ Full-Time Part-Time Retired Unemployed Other

Phone Day: _____ Cell: _____ Evening: _____

Preferred Phone: (Please circle or rate in order of preference.) Phone: Day ___ Cell ___ Evening ___

Email: _____ Do you check email regularly: Y/N

Living Situation: Spouse Alone Partner(s) Parents Children Other

How did you hear about Bio-Identical Hormone Replacement Therapy: Ad Another Patient

Friend Physician/Healthcare Practitioner Books/Articles Course/Seminar Other

If you had a referral, who referred you? _____

Do you understand what Bio-Identical Hormone Replacement is? _____

What are your goals for Bio-Identical Hormone Replacement Therapy? _____

Primary Care Physician: _____ Phone: _____

OB GYN: _____ Phone: _____

Address: _____ Fax: _____

Other Physicians Currently Seeing: _____

MEDICAL STATUS

Age:	General Health			
Weight:	Excellent	Good	Fair	Poor
Height:	Energy Level			
Blood Type:	High	Moderate	Low	

Drug Allergies

Medication	Response

Food/Other Allergies

Food, etc.	Response

History of Hormone Therapy Use (Please list in order – beginning with first medication used)

Date Started	Hormone/Strength	Daily Dose	Reason for Change

CURRENT AND PAST MEDICAL CONDITIONS:

Please check the ones that apply to you

	Y	N	Date of Diagnosis		Y	N	Date
Heart Disease				High Blood Pressure			
Stroke				Varicose Veins			
Clotting Defects				Diabetes			
Kidney Trouble				Epilepsy			
Fractures				Arthritis			
Colitis				Gallbladder trouble			
Irritable Bowel				Asthma			
Ulcers				Autoimmune Disorder			
Fibromyalgia				Osteoporosis			
Chronic Fatigue				Cancer			
Eating Disorder				High Cholesterol			

FAMILY HISTORY:

Please check all that apply to your family and to whom it applies

Medical Condition	Family member(s) diagnosed with medical condition
Diabetes	
Heart Disease	
Breast Cancer	
Ovarian Cancer	
Prostate Cancer	
Osteoporosis	

LIFESTYLE:

Dietary Restrictions: _____

Meal Choices: Breakfast: _____

Lunch: _____

Dinner: _____

Do you get routine exercise: _____ What type: _____ How often: _____

Do you use tobacco products: Y N How much: _____ How Long: _____Do you use alcohol products: Y N How much: _____ How Long: _____Do you use caffeine products: Y N How much: _____ How Long: _____

Do you have symptoms of hypoglycemia (Do you get headaches, dizzy, or irritable if you miss a meal)? _____

Stress level: High: _____ Moderate: _____ None: _____ Can't handle stress: _____

What type of stressors do you have in your life: _____

GYNECOLOGICAL HISTORY:

Age at first period: _____ Date of last period: _____

Date of last pelvic exam: _____ and Pap smear: _____ Results: _____

Have you ever had an abnormal pap? Y N Treatment: _____Are you sexually active: Y N Are you trying to get pregnant? Y N

Current birth control method: _____ How Long: _____

Problem with it: _____ How Long: _____

Past birth control and related problems: _____

Have you ever been on birth control? Y N Brand: _____ How Long: _____

Days from start of one period to the start of next: ____ Days of flow: ____ Amount of bleeding: _____

Do you have PMS symptoms? Yes: _____ No: _____			
If yes, when do symptoms start and stop: _____ PMS patients please fill in this section			
PMS – A	PMS – H	PMS – C	PMS – D
__ Nervous tension	__ Weight gain	__ Headache	__ Depression
__ Mood swings	__ Water retention	__ Cravings	__ Forgetfulness
__ Irritability	__ Breast tenderness	__ Heart palpitations	__ Crying
__ Anxiety	__ Bloating	__ Fatigue	__ Insomnia

Amount of cramps: _____ Any Clotting: _____

Any current changes in your normal cycle: _____

Any bleeding between periods: _____ When: _____

Any pelvic pain, pressure, or fullness: _____ Describe: _____

Any unusual vaginal discharge or itching: _____ Describe: _____

Treatment: _____

Age at first pregnancy: _____ How many full term pregnancies: _____ Problems: _____

Any interrupted pregnancies: Miscarriages Y N Abortions Y N Which pregnancy: _____Have you had a tubal ligation: Y N When: _____ Cycle or symptoms change after: _____Have you had a hysterectomy: Y N When: _____ Why: _____

Symptoms change after: _____

Have you had any part whole ovary or both ovaries removed When: _____ Why: _____

Symptoms change after: _____

History of Ovarian Cysts: Y N When: _____ History of Endometriosis: Y N When: _____

SYMPTOM ASSESSMENT:

Patient Name: _____

Date: _____

Top three biggest concerns / symptoms:

1. _____ Since When: _____
2. _____ Since When: _____
3. _____ Since When: _____

CODE *	SYMPTOM	NONE 0	MILD 1	MODERATE 2	SEVERE 3
A	Acne				
AN	Anxiety/Nervous				
BB	Breakthrough Bleeding				
BT	Breast Tenderness				
C	Cramps				
-SD	Decreased Sex Drive				
D	Depression				
DS	Dry Skin				
F	Fatigue				
FB	Fibrocystic Breast				
FR	Fluid Retention				
HL	Hair Loss				
HRC	Hard to Reach Climax				
H	Headaches				
HF	Hot Flashes				
LBC	Incontinence/loss of bladder control				
PS	Poor sleep/Insomnia (trouble falling asleep)				
I	Irritability				
MS	Mood Swings				
NS	Night Sweats				
PJ	Painful Joints				
PM	Poor Memory				
PSD	Poor sleep/Disruptions (trouble staying asleep)				
VD	Vaginal Dryness				
+W	Weight Gain (list lbs. or inches)				

* Use code for charting symptoms on Symptoms Journal/Calendar.

Other Symptoms: _____
