Custom Medicine PHARMACENTER
Precisely What The Doctor Ordered

CONFIDENTIAL HORMONE EVALUATION

MEDICAL HISTORY

Today's Date: _____

Name: _____ Birthdate: _____ Age: _____

Address:_____

City: _____ State: _____ Zip: _____

Daytime Phone:_____ E-Mail Address:_____

Gender: ❑Male ❑Female Height: _____ Weight: _____

			How often and how much?
Do you use tobacco?	❑Yes	❑No	_____
Do you use alcohol?	❑Yes	❑No	_____
Do you use caffeine?	❑Yes	❑No	_____

Name: _____

Doctor Name/Specialty: **Phone:**

_____

_____

_____

_____

Allergies: Please check all that apply.

❑ penicillin ❑ morphine ❑ dye allergies ❑ pet allergies
❑ codeine ❑ aspirin ❑ lactose/gluten ❑ 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 (e.g.: Tylenol®)
❑ Ibuprofen (e.g.: Motrin IB®)
❑ Naproxen (e.g.: Aleve®)
❑ Ketoprofen (e.g.: Orudis KT®)
❑ Cough suppressant (e.g.: Robitussin DM®)
❑ Antihistamine product (e.g: Chlor-Trimeton®)
❑ Decongestant product (e.g: Sudafed ®)
❑ Combination product (cough+cold reliever)(e.g.: Triaminic DM®)
❑ Sleep aids (e.g.: Excedrin PC®, Unisom®, Sominex®, Nytol®)
❑ Antidiarrheals (e.g.:Imodium®, Pepto Bismol®, Kaopectate®)
❑ Laxatives/stool softeners (e.g.: Doxidan®, Correctol®, etc.)
❑ Diet aids/weight loss products (e.g.: Dexatril®)
❑ Antacids (e.g.: Maalox®, Mylanta®)
❑ Acid blockers (e.g.: Tagamet HB®, Pepcid C®, Zantac 75®)
❑ Other (please list)_____ _____
_____

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

- ❑ vitamins (e.g.: multiple or single vitamins such as B complex, E, C, beta carotene)
- ❑ minerals (e.g: calcium, magnesium, chromium, colloidal minerals, various single minerals)
- ❑ herbs (e.g: Ginseng, Ginkgo Biloba, Echinacea, other herbal medicinal teas, tinctures, remedies, etc.)
- ❑ enzymes (e.g: digestive formulas, papaya, bromelain, CoEnzyme Q10, etc.)
- ❑ nutrition/protein supplements (e.g: shark cartilage, protein powers, amino acids, fish oils, etc.)
- ❑ others (glucosamine, etc.)
- ❑ None

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

- ❑ Heart disease (e.g.: Congestive Heart Failure)
- ❑ High cholesterol or lipids (e.g.: Hyperlipidemia)
- ❑ High blood pressure (e.g.: Hypertension)
- ❑ Cancer
- ❑ Ulcers (stomach, esophagus)
- ❑ Thyroid disease
- ❑ Hormonal Related Issues
- ❑ Lung condition (e.g.: asthma, emphysema, COPD)
- ❑ Blood Clotting Problems
- ❑ Diabetes
- ❑ Arthritis or joint problems
- ❑ Depression
- ❑ Epilepsy
- ❑ Headaches/migraines
- ❑ Eye Disease (glaucoma, etc.)
- ❑ Other: Please list: _____

Current Prescription Medications:

Medication Name Strength Date Started How often per day.

_____
_____
_____
_____

List Hormones previously taken. Date Started Date Stopped Reason

_____
_____
_____
_____

Bone Size: ❑ Small ❑ Medium ❑ Large

Have you ever used oral contraceptives? ❑ No ❑ Yes
Any problems? ❑ No ❑ Yes
If YES, describe any problem(s).

_____
_____
_____
_____

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

Any interrupted pregnancies? ❑No ❑Yes

Have you had a hysterectomy? ❑No ❑Yes (Date of Surgery) _____
Ovaries removed? ❑No ❑Yes

Have you had a tubal ligation? ❑No ❑Yes (Date) _____

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

❑ Uterine Cancer - Family member(s) _____
❑ Ovarian Cancer - Family member(s) _____
❑ Fibrocystic breast - Family member(s) _____
❑ Breast Cancer - Family member(s) _____
❑ Heart Disease - Family member(s) _____
❑ Osteoporosis - Family member(s) _____
❑ Alzheimer's - Family member(s) _____

Have you had any of the following tests performed? Check those that apply and note date of last test.

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 Date: _____

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

_____
_____
_____
_____
_____

When was your last period? _____

How many days did it last? _____

Do you have, or did you ever have Premenstrual Syndrome (PMS)? ❑No ❑Yes
If YES, explain symptoms and rate severity:

_____
_____
_____

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

❑ Doctor ❑ Self ❑ Friend/Family Member ❑ Book ❑ Internet ❑Other_____

What are your goals with taking BHRT?

_____
_____
_____
_____
_____
_____
_____

Please list any other medical issues you feel need to be addressed. (e.g. hair loss, itchy skin, etc.)

_____
_____
_____
_____

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

_____
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NAME:_____ DATE:_____

HORMONE REPLACEMENT THERAPY PATIENT INFORMATION SHEET

	ABSENT	MILD	MODERATE	SEVERE
Anxiety	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Bladder Symptoms	_____	_____	_____	_____
Breakthrough Bleeding	_____	_____	_____	_____
Breast Tenderness	_____	_____	_____	_____
Cramps	_____	_____	_____	_____
Decreased Sex Drive	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Dry Skin/Hair	_____	_____	_____	_____
Fatigue	_____	_____	_____	_____
Fibrocystic Breast	_____	_____	_____	_____
Fluid Retention	_____	_____	_____	_____
Hair Loss	_____	_____	_____	_____
Harder to Reach Climax	_____	_____	_____	_____
Headaches	_____	_____	_____	_____
Heavy/Irregular menses	_____	_____	_____	_____
Hot Flashes	_____	_____	_____	_____
Irritability	_____	_____	_____	_____
Loss of Memory	_____	_____	_____	_____
Mood Swings	_____	_____	_____	_____
Night Sweats	_____	_____	_____	_____
PMS	_____	_____	_____	_____
Sleep Disturbances/Insomnia	_____	_____	_____	_____
Vaginal Dryness	_____	_____	_____	_____
Weight Gain	_____	_____	_____	_____

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