Skip's Pharmacy

Confidential Hormone Replacement Evaluation

All information provided will be kept confidential.

Today's Date				
Name				
Address				
Telephone numbers				
Email				
Age	Birth Date	Gender	Male	Female
Height	Weight			
Doctors Name				
Address				
Phone				

Allergies:

Please circle all that apply:

penicillin	codeine	sulfa drugs
morphine	aspirin	food allergies
dye allergies	nitrate allergy	no known allergies
pet allergies	seasonal (pollen) allergies	other

Please describe the allergic reactions you experienced and when they occurred.

Do you participate in routine physical exercise? Yes/ No/ What type?

Over-The-counter (OTC) Use

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

- ☐ Pain Reliever / Analgesics
- ☐ Cough suppressant (ex:Robitussin DM)
- ☐ Antihistamine product (ex:Chlor-Trimetone)
- ☐ Decongestant product (ex:Sudafed)
- ☐ Combination product (cough plus cold releiver) (ex:Triaminic DM)
- ☐ Sleep Aids (ex:Excedrin PC,Sominex, Nytol)
- ☐ Antidiarrheals (ex:Imodium,Pepto-Bismol,Kaopectate)
- ☐ Laxative/stool softeners (ex:Doxindan, Correctol)
- ☐ Diet Aids/weight loss products (ex: Dexadril)
- ☐ Antacids (ex:Maalox,Mylanta)
- ☐ Acid Blockers (ex: Tagament HB, Pepcid CD, Zantac 75
- ☐ OTC Progesterone
- ☐ Yam Creams
- ☐ Other: (Please list)

Please Explain:

Medical Conditions/Disease

- ☐ Heart Disease (ex: Congestive Heart failure)
- ☐ High Cholesterol and Lipids
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Ulcers (stomach, esophagus)
- ☐ Thyroid Disease
- ☐ Hormone Related Issues
- ☐ Lung Conditions : (ex: asthma, emphysema, COPD)
- ☐ Blood Clotting Problems
- ☐ Diabetes
- ☐ Arthritis or joint problems
- ☐ Depression
- ☐ Epilepsy
- ☐ Headaches; Migraines
- ☐ Eye disease (glaucoma, etc)
- ☐ Other: Please list:

Please Explain:

Current Prescribed Medications:

Medication Name	Strength	Date Started	How often per day

Hormones Previously taken:

Hormone name	Date started	Date Stopped	Reason

Nutritional Supplements:

Please identify and list the products that you are using:

- ☐ Vitamins (multiple or single vitamins)
- ☐ Minerals (calcium, magnesium, chromium, colloidal minerals)
- ☐ herbs (Ginsing, Gingko Biloba, Echanesia, teas, tinctures)
- ☐ Enzymes: (digestive formulas, papaya, bromelain, Co-enzyme Q10)
- ☐ Nutrition/protein supplement (protein powders, amino acids, fish oils)
- ☐ others:

Please Explain:

Pregnancy

How many pregnancies have you had? How many children?

Any interrupted pregnancies? no yes

Have you had a hysterectomy? no yes Date of surgery ___/___/___ (mm dd yyyy)

Were your ovaries removed ? no yes

Have you had a tubal ligation? no yes Date of surgery ___/___/___ (mm dd yyyy)

Family History

Do you have a family history of the following?

		Please Explain:
Uterine Cancer	family member	
Ovarian Cancer	family member	
Fibro-Cystic Breast	family member	
Breast Cancer	family member	
Heart Disease	family member	
Osteoporosis	family member	

Medical History

Have you ever had a mammogram ? no yes Date: ___/___/___ (mm dd yyyy)

Results:

Have you had a PAP smear ? no yes Date: ___/___/___ (mm dd yyyy)

Results:

Have you ever used oral contraceptives? no yes

Did you have any problems? no yes

If YES, describe any problem(s)

Do you use Tobacco? Yes No

Do you use Alcohol? Yes No

Do you use Caffeine? Yes No

Bone size: Small Medium Large

Body type:

Androgenic(masculine) Estrogenic(Feminine)

Patient Information Sheet

	Absent	Mild	Moderate	Severe
Fibrocystic Breasts				
Weight Gain				
Heavy, Irregular Menses				
Hot Flushes				
Dry Hair/Skin				
Anxiety				
Depression				
Night Sweats				
Vaginal Dryness				
Headaches				
Irritability				
Mood Swings				
Breast Tenderness				
Sleep Disturbances/Insomnia				
Cramps				
Fluid Retention				
Breakthrough Bleeding				
Fatigue				
Loss of Memory				
Bladder Symptoms				
Arthritis				
Hard to Reach Climax				
Decreased Sex Drive				
Hair loss				

Menstrual History

Since you first began menstruating, have you ever had what you would consider abnormal cycles?

no yes Date:

If yes please explain: (age, symptoms etc)

When was your last period? ___/___/___ How many days did it last?
mm dd yyyy

Do you have, or did you have Premenstrual Syndrome (PMS)? No Yes

If yes explain symptoms:

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

Physician/Healthcare practitioner Self Friend/Family Member Books/articles Others

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

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

Hormone Replacement Therapy