Town & Country
Compounding and Consultation

"Customized, Patient Specific, Compounded Medications"

Confidential BHRT 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.

Today's Date: _____

Name: _____ **Birthdate:** _____ **Age:** _____

Address:_____

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

Phone: _____ **E-Mail Address:** _____

Work Phone: _____**Occupation**:_____

Full time_____ **Part-time**_____ **Retired**_____**Unemployed**_____**Other**_____

Living Situation: Spouse_____ Partner_____ Friend(s)_____ Parents _____ Children_____Other_____

Status: Married_____ Single_____ Divorced_____ Widowed _____

Pets:_____

How did you hear about natural hormone replacement therapy? Ad____ **Another Patient**_____

Course/Seminar_____ **Physician/Health Care Practitioner**_____ **Books/Articles**____ **Other**____

Do you understand what natural hormone replacement is? _____

What are your goals for Natural Hormone Replacement? _____

_____

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MEDICAL STATUS

General Health: Excellent_____ **Good**_____ **Fair**_____ **Poor**_____

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 _____

Doctor's Name: _____

Address: _____

Phone: _____

_____

Current Diagnosis or Medical Conditions: _____

_____

Allergies: Please check all that apply.

_____ penicillin _____ morphine _____ dye allergies _____ pet allergies

_____ codeine _____ aspirin _____ nitrate allergies _____ seasonal (pollen) allergies

_____ sulfa drug _____ food allergies _____ no known allergies

other: _____

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

_____

_____

_____

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Current Medications (how often per day) _____

_____

_____

_____

_____

_____

Over-the-counter (OTC) issues: Please check all products that you use occasionally or regularly. **Check all that apply.**

_____ Pain Reliever _____ Combination product (cough+cold reliever) (ex: Triaminic DM®)

_____ Aspirin _____ Sleep aids (ex: Excedrin PC®, Unisom®, Sominex®, Nytol®)

_____ Acetaminophen (example: Tylenol®) _____ Antidiarrheals (ex: Imodium®, Pepto Bismol®, Kaopectate®)

_____ Ibuprofen (example: Motrin IB®) _____ Laxatives/stool softeners (examples: Doxidan®, Correctol®, etc.)

_____ Naproxen (example: Aleve®) _____ Diet aids/weight loss products (example: Dexatril®)

_____ Ketoprofen (example: Orudis KT®) _____ Antacids (examples: Maalox®, Mylanta®)

_____ Cough suppressant (ex: Robitussin DM®) _____ Acid blockers (ex: Tagamet HB®, Pepcid ®, Zantac 75®)

_____ Antihistamine product (example: Chlor-Trimeton®) _____ Decongestant product (example: Sudafed ®)

Other (please list):_____

_____

_____

Nutritional/Natural Supplements: Please identify the products used.

_____ Vitamins (examples: multiple or single vitamins such as B complex, E, C, beta carotene)

_____ Minerals (examples: calcium, magnesium, chromium, colloidal minerals, various single minerals)

_____ Herbs (examples: Ginseng, Ginkgo Biloba, Echinacea, other herbal medicinal teas, tinctures, remedies, etc.)

_____ Enzymes (examples: digestive formulas, papaya, bromelain, CoEnzyme Q10, etc.)

_____ Nutrition/protein supplements (examples: shark cartilage, protein powers, amino acids, fish oils, etc.)

_____ Others (glucosamine, etc.) _____

_____

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

_____ Heart disease (example: Congestive Heart Failure) _____ Blood Clotting Problems

_____ High cholesterol or lipids (examples: Hyperlipidemia) _____ Diabetes

_____ High blood pressure (example: Hypertension) _____ Arthritis or joint problems

_____ Cancer _____ Depression _____Varicose Veins _____Kidney Trouble _____Fractures

_____Arthritis _____Colitis _____Gallbladder Trouble _____Asthma _____Chronic Fatigue

_____Fibromyalgia _____Eating Disorder _____Cancer _____ Ulcers (stomach, esophagus) _____ Epilepsy

_____Thyroid disease _____ Headaches/migraine _____ Hormonal Related Issues_____ Eye Disease (glaucoma,etc)

_____ Lung condition (example: asthma, emphysema, COPD)

Other: Please list: _____

Habits: _____

Dietary Restrictions: _____

Meal Choices:

Breakfast: _____

Lunch: _____

Dinner: _____

Do you get routine physical exercise? _____ **What type?**_____

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GYNECOLOGICAL HISTORY

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).

_____

_____

_____

How many pregnancies have you had? _____ How many children_____

Age at first pregnancy: _____

Any problems with pregnancies? _____

_____

Any interrupted pregnancies? (miscarriage or abortion) _____No _____Yes

Have you had a hysterectomy? _____No _____Yes (Date of Surgery) _____

Have you had any part or whole ovary 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) _____

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Fibrocystic breast _____ Family member(s) _____

Breast Cancer _____ Family member(s) _____

Heart Disease _____ Family member(s) _____

Osteoporosis _____ Family member(s) _____

Diabetes_____ 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: _____

Pelvic Exam _____No _____Yes Date: _____

Results:_____

Have you ever had an abnormal pap? _____ Treatment:_____

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….):

_____

_____

_____

_____

Age at first Period:_____ 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: _____

_____

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Are you sexually active? _____ Are you trying to get pregnant?_____

Current Birth Control Method: _____ How Long?_____

Past Birth Control and any related problems: _____

How many days from start of one period to start of the next?_____

Number of days of flow: _____ Amount of bleeding:_____

Amount of Cramps: _____

Premenstrual Symptoms: _____

Starting and ending when: _____

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: _____

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?

_____

_____

_____

_____

_____

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

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HORMONE REPLACEMENT THERAPY PATIENT INFORMATION SHEET

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

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	ABSENT	MILD	MODERATE	SEVERE
Decreased Sex Drive	_____	_____	_____	_____
Hair Loss	_____	_____	_____	_____
Low Libido	_____	_____	_____	_____
Swollen Breasts	_____	_____	_____	_____
Moodiness	_____	_____	_____	_____
Fuzzy Thinking	_____	_____	_____	_____
Food Cravings	_____	_____	_____	_____
Bloating	_____	_____	_____	_____
Shortness of breath	_____	_____	_____	_____
Heart Palpitations	_____	_____	_____	_____
Frequent Yeast Infections	_____	_____	_____	_____
Vaginal Shrinking	_____	_____	_____	_____
Loss of Pubic Hair	_____	_____	_____	_____
Painful Intercourse	_____	_____	_____	_____
Weight Gain (Hips/Thighs)	_____	_____	_____	_____
Symptoms of Low Thyroid	_____	_____	_____	_____

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Consultant Notes:

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