

Carel's Pharmacy & Compounding Center

Bio-Identical Hormone Replacement

Confidential Patient 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.

Please take your time and fill out this form completely. The more thorough you are, the better we are able to meet your needs. There is a \$95.00 charge for this personal hormone consultation that is due at the time of consultation.

GENERAL INFORMATION

Date: _____

Name: _____ DOB: _____ Driver License #: _____

Address: _____ City _____ State _____ Zip _____

Home Phone No: _____ Work Phone No: _____ Cell Phone No: _____

Email address: _____

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

Marital Status: _____ Who do you live with? _____

How did you hear about Bio-Identical Hormone Replacement (BHRT)? _____

Do you understand what BHRT is? _____ What are your goals for BHRT? _____

Are you interested in customized skin care solutions? _____ If so please ask for skin care form.

INSURANCE INFORMATION (Prescription Insurance)

Cardholder: _____ Relationship to Cardholder _____

Plan Name: _____ RX Bin No. _____

Group Number: _____ ID Number _____

MEDICAL STATUS

General Health: Excellent ___ Good ___ Fair ___ Poor ___ Height: _____ Weight: _____

Current Diagnosis or medical conditions: _____

Drug Allergies: _____

Allergies to food, pollens, etc.: _____

Current Medications & Dose: _____

Any Previous Hormone Replacement Medications & Dose: _____

Current Vitamins/OTC products/Herbs & Dose: _____

Have you ever had your cholesterol level checked? _____ Date: _____ Results: _____

Have you ever had a mammogram? _____ Date: _____ Results: _____

Have you ever had a bone density scan? _____ Date: _____ Results: _____

Current Physician(s) _____

PAST MEDICAL CONDITIONS:

Childhood diseases: _____

Heart Trouble _____ High Blood Pressure _____ Stroke _____ Varicose Veins _____

Clotting Defects _____ Diabetes _____ Kidney Trouble _____ Epilepsy _____

Fractures _____ Arthritis _____ Colitis _____ Gallbladder Trouble _____ Asthma _____

Chronic Fatigue _____ Fibromyalgia _____ Eating Disorder _____ Cancer _____

HABITS

Dietary Restrictions: _____

Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner: _____

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

Do you use tobacco products? _____ How much? _____ Previously? _____ How long? _____

Do you use alcohol products? _____ How much? _____ Previously? _____ How long? _____

Do you use caffeine products? _____ How much? _____

FAMILY HISTORY

Please list family members, their age or age of death that may have important diseases

such as: High Blood Pressure, Heart Disease, Cancer, Diabetes, Osteoporosis, etc.: _____

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? _____ Treatment: _____

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

Current birth control method: _____ How long? _____

Past birth control and any related problems: _____

NOTE: If you are not currently menstruating, please complete this section using historical information.

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

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

Amount of cramps: _____

Premenstrual symptoms: _____

Any current changes in your normal cycle: _____

Any pelvic pain, pressure, or fullness: _____ Any unusual vaginal discharge or itching: _____

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

Problems: _____

Any interrupted pregnancies (miscarriages or abortions)? _____

Have you had a tubal ligation? _____ When? _____

Have you had a hysterectomy? _____ When? _____

What was the reason for the hysterectomy? _____

Do your ovaries remain? _____

Do you have any history of Fibrocystic Breasts? _____

Do you have any history of Uterine Fibroids or Cysts? _____

SYMPTOMS

	Absent	Mild	Moderate	Severe
Headaches	_____	_____	_____	_____
Low Libido	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____
Swollen or Tender Breasts	_____	_____	_____	_____
Fibrocystic Breasts	_____	_____	_____	_____
Fuzzy Thinking	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Food Cravings	_____	_____	_____	_____
Irritability	_____	_____	_____	_____
Insomnia	_____	_____	_____	_____
Cramps	_____	_____	_____	_____

Emotional/Mood Swings	_____	_____	_____	_____
Weight Gain	_____	_____	_____	_____
Bloating	_____	_____	_____	_____
Inability to Concentrate	_____	_____	_____	_____
Hot Flashes	_____	_____	_____	_____
Shortness of Breath	_____	_____	_____	_____
Night Sweats	_____	_____	_____	_____
Vaginal Dryness	_____	_____	_____	_____
Dry Hair/Skin	_____	_____	_____	_____
Hair Loss	_____	_____	_____	_____
Short Term Memory Loss	_____	_____	_____	_____
Frequent Urinary Tract/Yeast Infections	_____	_____	_____	_____
Heart Palpitations	_____	_____	_____	_____
Vaginal Shrinking	_____	_____	_____	_____
Loss of Pubic Hair	_____	_____	_____	_____
Painful Intercourse	_____	_____	_____	_____
Inability to Reach Orgasm	_____	_____	_____	_____
Fatigue Lack of Energy	_____	_____	_____	_____
Heavy or Irregular Menses	_____	_____	_____	_____
Uterine Fibroids	_____	_____	_____	_____

Additional Comments and/or Information _____
