

Collier Drug Bio-Identical Hormone Evaluation Form

Today's Date: __/__/__

Name: _____ Birthdate: __/__/__ Age: _____

Address: _____ City: _____ State: _____

Zip: _____ Phone: _____ Email Address: _____

Gender: Male Female Height: _____ Weight: _____

Do you use tobacco? Yes No How often & how much? _____

Do you use alcohol? Yes No How often & how much? _____

Do you use caffeine? Yes No How often & how much? _____

Doctor's Name	Phone	Address

Allergies: Please check all that apply.

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

Other: _____

Please describe the reaction you experienced and when it occurred?

Over-the-counter (OTC) issues:

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

- Pain Reliever
- Aspirin
- Acetaminophen (example: Tylenol®)
- Ibuprofen (example: Motrin IB®)
- Naproxen (example: Aleve®)
- Ketoprofen (example: OrudisKT®)
- Cough Suppressant (example: Robitussin DM®)
- Antihistamine (example: Chlor-Trimeton®)
- Decongestant (example: Sudafed®)
- Combination (cough+cold reliever) (example: Triaminic DM®)
- Sleep Aids (examples: Excedrin PM®, Unisom, Sominex®, Nytol®)
- Antidiarrheals (examples: Imodium®, Pepto Bismol®, Kaopectate®)
- Laxatives/stool softeners (examples: Doxidan®, Correctol®)
- Diet aids/weight loss products (examples: Dexatril®)
- Antacids (examples: Maalox®, Mylanta®)
- Acid blockers (examples: Tagamet HB®, Pepcid C®, Zantac 75®)

Others: Please list:

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

- Heart Disease (example: Congestive Heart Failure)
- High cholesterol or lipids (example: Hyperlipidemia)
- High Blood Pressure (example: Hypertension)
- Cancer
- Ulcers (stomach, esophagus)
- Thyroid disease
- Hormonal related items
- Lung conditions (examples: asthma, emphysema, COPD)
- Blood clotting problems
- Diabetes

- Arthritis or joint problems
- Depression
- Epilepsy
- Headache/migraines
- Eye disease (glaucoma, etc.)
- Others: Please list:

Current Prescription Medications:

Medication Name	Strength	Date Started	How Often Per Day

List Hormones previously taken:

Have you ever used oral contraceptives? Yes No

Any problems? Yes No

If yes, describe any problems:

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

Any interrupted pregnancies? No Yes

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

Have you had your 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 _____

Ovarian Cancer _____ Family Member _____

Fibrocystic Breast _____ Family Member _____

Breast Cancer _____ Family Member _____

Heart Disease _____ Family Member _____

Osteoporosis _____ Family Member _____

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 (age, symptoms, etc...)

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 please explain symptoms:

Hormone Replacement Therapy Patient Information Sheet

Symptom	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 Disturbances/Insomnia				
Cramps				
Fluid Retention				
Breakthrough Bleeding				
Fatigue				
Loss of Memory				
Bladder Symptoms				
Arthritis				
Harder to Reach Climax				
Decreased Sex Drive				
Hair Loss				