Women's Bio-Identical Hormone Evaluation Form

TODAY'S DATE ____ / ____ / ____

BIRTHDATE ____ / ____ / ____ AGE ____

NAME

HEIGHT ____ WEIGHT ____

ADDRESS:

DO YOU USE TOBACCO? **YES** **NO**
HOW OFTEN, HOW MUCH?

CITY

DO YOU USE ALCOHOL? **YES** **NO**
HOW OFTEN, HOW MUCH?

STATE

ZIP CODE

PHONE

DO YOU USE CAFFEINE? **YES** **NO**
HOW OFTEN, HOW MUCH?

EMAIL

DOCTOR'S NAME	PHONE	OFFICE ADDRESS

ALLERGIES (PLEASE CHECK ALL THAT APPLY TO YOU.)

[ ] 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 IN OCCURRED:

Collier
DRUG STORES

Bio-Identical Hormone Evaluation form cont.

OVER-THE-COUNTER ISSUES (PLEASE CHECK ALL THAT APPLY TO YOU.)

[ ] Aspirin
[ ] Acetaminophen (ex: Tylenol®)
[ ] Ibuprofen (ex: Advil® or Motrin IB®)
[ ] Naproxen (ex: Aleve®)
[ ] Cough suppressant (ex: Robitussin DM®)
[ ] Antihistamine (ex: Chlor-Trimeton®)
[ ] Decongestant (ex: Sudafed®)
[ ] Vitamins or Herbs : ....

[ ] Combination (cough + cold releiver/ex: Triminc DM®)
[ ] Sleep aids (ex: Exedrin PM®, Unisom, Sominex®, Nytol®)
[ ] Antidiarrheals (ex: Imodium®, Pepto Bismol®)
[ ] Laxatives/stool softeners (ex: Colace®, Correctol®)
[ ] Diet aids/weight loss products (ex: Dexatril®)
[ ] Antacids (ex: Maalox®, Mylanta®)
[ ] Acid blockers (ex: Tagamet HB®, Pepcid C®, Prilosec®)
[ ] Others : ....

MEDICAL CONDITIONS/DISEASES (PLEASE CHECK ALL THAT APPLY TO YOU.)

[ ] Heart disease (ex: Congestive Heart Failure)
[ ] High cholesterol or lipids (ex: Hyperlipidemia)
[ ] High blood pressure (ex: Hypertension)
[ ] Cancer
[ ] Ulcers (stomach, esophagus)
[ ] Thyroid disease
[ ] Hormonal related items
[ ] Lung conditions (ex: asthma, emphysema, COPD)
[ ] Blood clotting problems

[ ] Diabetes
[ ] Arthritis or joint problems
[ ] Depression
[ ] Epilepsy
[ ] Headache/migraines
[ ] Eye disease (ex: Glaucoma, etc.)
[ ] Others:

CURRENT PRESCRIPTION MEDICATIONS:

MEDICATION NAME	STRENGTH	DATE STARTED	HOW OFTEN PER DAY

LIST HORMONES PREVIOUSLY TAKEN:

Collier DRUG STORES

Bio-Identical Hormone Evaluation form cont.

HAVE YOU EVER USED ORAL CONTRACEPTIVES? YES NO ANY PROBLEMS? YES NO

IF YES, PLEASE DESCRIBE:

HOW MANY PREGNANCIES HAVE YOU HAD? HOW MANY CHILDREN?

ANY INTERRUPTED PREGNANCIES? YES NO

HAVE YOU HAD A HYSTERECTOMY? YES NO / DATE OF SURGERY: / /

HAVE YOU HAD YOUR OVARIES REMOVED? YES NO

HAVE YOU HAD TUBAL LITIGATION? YES NO / DATE OF SURGERY: / /

DO YOU HAVE A FAMILY HISTORY 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 EITHER OF THE FOLLOWING TEST PERFORMED:

MAMMOGRAPHY? YES NO / DATE:

PAP SMEAR? YES NO / DATE:

SINCE YOU FIRST BEGAN HAVING PERIODS, HAVE YOU EVER HAD WHAT YOU WOULD CONSIDER TO BE ABNORMAL CYCLES? YES NO

IF YES, PLEASE EXPLAIN (AGE, SYMPTOMS, DATES, ETC.)

WHEN WAS YOUR LAST PERIOD?

HOW MANY DAYS DID IT LAST?

DO YOU, OR DID YOU EVER, HAVE PREMENSTRUAL SYNDROME (PMS)? YES NO

IF YES, PLEASE EXPLAIN (AGE, SYMPTOMS, DATES, ETC.)

Collier DRUG STORES

Bio-Identical Hormone Evaluation form cont.

PATIENT INFORMATION SHEET

	ABSENT 1	MILD 2	MODERATE 3	SEVERE 4	COMMENT
Fibrocystic breast					
Weight gain					
Heavy / irregular mensus					
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					
Facial hair					

WHAT ARE YOUR GOALS WITH TAKING BHRT?

PLEASE WRITE ANY QUESTIONS YOU MAY HAVE: