1000 Breuckman Drive
Crown Point, Indiana 46307
Phone: **219-662-5602**
Fax: 219-661-9057

2701 Beech Street, Unit R
Valparaiso, IN 46383
Phone: **219-465-2181**
Fax: 219-464-4382

Questions Regarding
BioIdentical Hormone Replacement?
Call Us.

BIO-IDENTICAL HORMONE REPLACEMENT

CONFIDENTIAL **WOMAN'S EVALUATION** FORM

IMPORTANT! FAX or Deliver your Completed form to Custom Dosing Pharmacy at least 1 day in advance of your consultation.

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 in advising about current medical therapies. *All information provided will be kept confidential.*

GENERAL INFORMATION

Date:________________

Name:________________ Age:________ Birth Date:________

Street Address:________________ Apt:________

City:________________ State:________ Zip:________

Occupation:________________ ☐Full Time ☐Part Time ☐Unemployed ☐Other

Daytime Phone:________________ Evening Phone:________________ Cell:________________

E-Mail Address:________________

Living Situation: ☐Spouse ☐Alone ☐Partner ☐Friend(s) ☐Parents ☐Children ☐Other

Status: ☐Married ☐Single ☐Divorced ☐Widowed

How did you hear about Bio-Identical Hormone Replacement?________________

☐Pharmacy Employee ☐Ad ☐Patient ☐Friend ☐Seminar ☐Physician/Healthcare Referral ☐Book ☐Other

If referred, who referred you?________________

Have you discussed Bio-Identical HRT with you Healthcare Practitioner?________________

Do you understand what Bio-Identical Hormone Replacement Therapy is?________________

What are your 3 main symptoms/concerns?

1________________ Since when?________

2________________ Since when?________

3________________ Since when?________

MEDICAL STATUS

Primary Healthcare Practitioner/Physician:________________ Phone:________

Physician Address:________________ Fax:________

Other Physician(s) Currently Seeing:________________

General Health: ☐Excellent ☐Good ☐Fair ☐Poor Height:________ Weight:________

Allergies:______________________________ Blood Type:__________

Current Diagnosis or Medical Conditions:______________________________

____

Current Medications:______________________________

____

____

Current Vitamins or OTC Products: PLEASE LIST ALL! YOU MAY BRING IN PRODUCTS TO YOUR CONSULTATION.

____

____

Current Herb/etc:______________________________

Are you currently on Natural Progesterone Cream? ☐Yes ☐No If YES, brand name?__________

If YES, how long have you been on Progesterone Cream?__________ How much do you use?__________ When?__________

Current Hormone Replacement Therapy? NAME:__________ Strength:__________

Date Started:______________________________

How and When do you take current HRT?______________________________

Previous Hormone Replacement Therapy? NAME:__________ Strength:__________

Reason for Change?______________________________

____

ANY LAB RESULTS YOU MAY WISH TO ENCLOSE WOULD BE HELPFUL TO YOU EVALUATION

Exam/Lab Results:

		DATE	SERUM BLOOD	SALIVA	RESULTS
BLOOD					
FSH					
PROGESTERONE					
ESTRIOL (E3)					
ESTRADIOL (E2)					
ESTRONE (E1)					
TESTOSTERONE					
	TOTAL				
	FREE				
DHEA SULFATE					
CHOLESTEROL					
TRIGLYCERIDES					
	TOTAL				
	HDL				
	LDL				

Bone Density: ☐Yes ☐No Date:____________________ Type: ☐Back ☐Hip T-Score:______________________

Have you ever had a mammogram? ☐Yes ☐No Date:______________ Results:______________________________

Have you ever had your thyroid tested? ☐Yes ☐No Date:____________ Results:______________________________

CURRENT AND PAST MEDICAL CONDITIONS

Please check conditions that apply to you.

CONDITION	Y	N	Date of Diagnosis	CONDITION	Y	N	Date of Diagnosis
Heart Disease				High Blood Pressure			
Stroke				Varicose Veins			
Clotting Defects				Diabetes			
Kidney Trouble				Epilepsy			
Fractures				Arthritis			
Colitis				Gallbladder			
Irritable Bowel				Asthma			
Ulcers				Autoimmune Disorder			
Fibromyalgia				Osteoporosis			
Chronic Fatigue				Cancer			
Eating Disorder				Liver Disorders			
Other							

HABITS

Dietary Restrictions:____

Meal Choices: Breakfast:____

Lunch:____

Dinner:____

Do you get routine exercise? ☐Yes ☐No How Much?______________________ How Long?__________________

Do you use tobacco products? ☐Yes ☐No How Much?______________________ How Long?__________________

Do you use alcohol products? ☐Yes ☐No How Much?______________________ How Long?__________________

Do you use caffeine products? ☐Yes ☐No How Much?______________________ How Long?__________________

FAMILY HISTORY

LIVING	IMPORTANT DISEASES	LIVING	DECEASED
Mother			
Father			
Brothers			
Sisters			
Aunts			
Uncles			
Paternal Grandmother			
Paternal Grandfather			
Maternal Grandmother			
Maternal Grandfather			

SYMPTOM SHEET

Please Check the Appropriate Boxes Below:

	Absent	Mild	Moderate	Severe
Fibrocystic Breast				
Weight Loss				
Weight Gain				
Heavy/Irregular Menses				
Breakthrough Bleeding				
Hot Flashes				
Dry Skin/Hair				
Anxiety				
Depression				
Night Sweats				
Vaginal Dryness				
Headaches				
Heart Palpitations				
Irritability				
Mood Swings				
Breast Tenderness				
Sleep Disterbances/Insomnia				
Cramps/Bloating				
Fluid Retention				
Hair Loss				
Fatigue				
Fuzzy Thinking				
Frequent Urinary Tract Infections				
Arthritis				
Inability to Reach Orgasm				
Decreased Sex Drive				
Bone Loss				
Cravings (Sweets & Carbs)				

GYNECOLOGICAL HISTORY

Age at First Period: ______________________________ Date of Last Period: ____________________________________

Date of Last Pelvic Exam: ________________________ Date of Last Pap Smear: ______________ Results: ______________

Have you ever had an abnormal Pap? ☐Yes ☐No When? _____________________ How many times? ______________

Treatment: ____

Are you sexually active? ☐Yes ☐No Are you trying to get pregnant? ☐Yes ☐No

Birth control method: ____ How Long? ____________________

Any problem with it? ____ How Long? ____________________

Past birth control related problems? ____

Have you ever been on Birth Control Pills? ☐Yes ☐No Brand: _____________________ How long on Pill? __________

Side effects from Pill? ____

PLEASE FILL OUT NEXT SECTION EVEN IF NOT CYCLING NOW

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

Number of days of flow? _________________________ Amount of bleeding? _____________________________

Amount of cramping? ____

Premenstrual symptoms? ____

PMS starting and ending when? ____

Any current changes in your normal cycle? ____

Any bleeding between periods? ___________________ When? ____

Any pelvic pain, pressure or fullness? ☐Yes ☐No Describe: _______________________________________

Any unusual vaginal discharge or itching? ☐Yes ☐No Describe: ____________________________________

Treatment: ____

Age at first pregnancy? __________________________ How many full term pregnancies? ____________________

Pregnancy problems? ____

____

Any interrupted pregnancies? Miscarriages? ☐Yes ☐No Abortions? ☐Yes ☐No

Which pregnancy? _____________________________ How far along? __________________________________

Have you had a tubal ligation? ☐Yes ☐No When? ____

Cycle or symptom change after tubal ligation? ____

Have you had a hysterectomy? ☐Yes ☐No When? _________________________ Why? _____________________

____

Symptoms change after hysterectomy? ____

____

Have you had any part or whole ovary removed? ☐Yes ☐No When? __________________ Why? ________________

____

Symptom change after? ____

____

Mother's age at menopause? ____