PURE Compounding

Medical Problems ✂ Pharmacy Solutions

CONFIDENTIAL HORMONE EVALUATION

MEDICAL HISTORY

Today's Date: _____
Name: _____ **Birthdate:** _____ **Age:** _____
Address:_____
City: _____ **State:** _____ **Zip:** _____
Phone: _____
E-Mail Address_____
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:_____

Allergies: Please check all that apply.
___ penicillin ___ morphine ___ dye allergies ___ pet allergies
___ codeine ___ aspirin ___ nitrate allergy ___ seasonal (pollen) allergies
___ sulfa drug ___ food allergies ___ no known allergies
other: _____
Please describe the allergic reaction you experienced and when it occurred?

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)(example: Triaminic DM®)
___ Aspirin ___ Sleep aids (exmples: Excedrin PC®, Unisom®, Sominex®, Nytol®)
___ Acetaminophen (example: Tylenol®) ___ Antidiarrheals (examples: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 (example: Robitussin DM®) ___ Acid blockers (examples: Tagamet HB®, Pepcid C®, Zantac 75®)
___ Antihistamine product (example: Chlor-Trimeton®) ___ Other (please list)
___ Decongestant product (example: Sudafed ®) _____

PATIENT NAME: _____

Nutritional/Natural Supplements: Please identify and list all of the products you are using:

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.)

_____
_____
_____

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
___ Ulcers (stomach, esophagus) ___ Epilepsy
___ Thyroid disease ___ Headaches/migraines
___ Hormonal Related Issues ___ Eye Disease (glaucoma, etc.)
___ Lung condition (example: asthma, emphysema, COPD) ___
Other: Please list: _____

Current Prescription Medications

Medication Name Strength How often When started

_____
_____
_____
_____
_____

List Hormones previously taken.

Date Started Date Stopped Reason

_____
_____
_____
_____
_____

Bone Size _____ Small _____ Medium _____ Large _____
Body Type: Androgenic Estrogenic
Have you ever used oral contraceptives? No Yes
Any problems? No Yes
If YES, describe any problem(s).

_____
_____

PATIENT NAME: _____

How many pregnancies have you had? ____
How many children_____
Any interrupted pregnancies? No Yes
Have you had a hysterectomy? No Yes (Date of Surgery) _____
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(s) _____
Ovarian Cancer _____ Family member(s) _____
Fibrocystic breast _____ Family member(s) _____
Breast Cancer _____ Family member(s) _____
Heart Disease _____ Family member(s) _____
Osteoporosis _____ 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: _____
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 (such as age when this occurred, symptoms….):
_____
_____
_____
_____
_____
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:
_____
_____
_____

PATIENT NAME: _____

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?

_____
_____
_____
_____

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

_____
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Do you prefer a cream or capsule? _____

Patient Name: _____

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

Patient Name: _____