

ITC PHARMACY'S CONFIDENTIAL HORMONE EVALUATION

MEDICAL HISTORY

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Gender:  Male  Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Do you use tobacco?  Yes  No  
Do you use alcohol?  Yes  No  
Do you use caffeine?  Yes  No

How often and how much?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies: Please check all that apply

- |                                     |   |  |  |
|-------------------------------------|---|--|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Morphine       | <input type="checkbox"/> Dye allergies   | <input type="checkbox"/> Seasonal (pollen) allergies |
| <input type="checkbox"/> Codeine    | <input type="checkbox"/> Aspirin        | <input type="checkbox"/> Nitrate allergy | <input type="checkbox"/> No known allergies          |
| <input type="checkbox"/> Sulfa drug | <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Pet allergies   | <input type="checkbox"/> 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:

- |   |   |
|---|---|
| <input type="checkbox"/> Pain reliever                          | <input type="checkbox"/> Combination product (cough+cold reliever; e.g. Triaminic DM) |
| <input type="checkbox"/> Aspirin                                | <input type="checkbox"/> Sleep aids (e.g. Excedrin PC, Unisom, Sominex, Nytol)        |
| <input type="checkbox"/> Acetaminophen (e.g. Tylenol)           | <input type="checkbox"/> Antidiarrheals (e.g. Imodium, Pepto Bismol, Kaopectate)      |
| <input type="checkbox"/> Ibuprofen (e.g. Motrin IB)             | <input type="checkbox"/> Laxatives/stool softeners (e.g. Doxidan, Correctol)          |
| <input type="checkbox"/> Naproxen (e.g. Aleve)                  | <input type="checkbox"/> Diet aids/weight loss (e.g. Dexatril)                        |
| <input type="checkbox"/> Ketoprofen (Orudis KT)                 | <input type="checkbox"/> Antihistamine (e.g. Chlor-Trimeton)                          |
| <input type="checkbox"/> Decongestant (e.g. Sudafed)            | <input type="checkbox"/> Acid blockers (e.g. Tagamet HB, Pepcid C, Zantac 75)         |
| <input type="checkbox"/> Antacids (e.g. Maalox, Mylanta)        | <input type="checkbox"/> Other (please list)  |
| <input type="checkbox"/> Cough suppressant (e.g. Robitussin DM) |   |

How many pregnancies have you had? \_\_\_\_\_ How many children? \_\_\_\_\_

Any interrupted pregnancies?  No  Yes (Date of surgery) \_\_\_\_\_

Have you had an hysterectomy?  No  Yes  
Ovaries removed?  No  Yes

Have you had a tubal ligation?  No  Yes

Do you have a family history of any of the following: (Please check all that apply and note family member)

Uterine cancer	_____	Family member(s)	_____
Ovarian cancer	_____	Family member(s)	_____
Fibercystic 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	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date: _____
PAP smear	<input type="checkbox"/> No	<input type="checkbox"/> 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 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, please explain symptoms:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

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

Vitamins (e.g. multiple or single vitamins such as B complex, E, C, beta carotene)

Minerals (e.g. calcium, magnesium, chromium, colloids, various single minerals)

Herbs (e.g. Ginseng, Gingko Biloba, Echinacea, other herbal medicinal teas, tinctures, remedies, etc)

Enzymes (e.g. digestive formulas, papaya, bromelain, CoEnzyme Q10, etc)

Nutrition/protein supplements (e.g. shark cartilage, protein powders, amino acids, fish oils, etc)

Others (glucosamine, etc)

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

<input type="checkbox"/> Heart disease (e.g. Congestive heart failure)	<input type="checkbox"/> Blood clotting problems
<input type="checkbox"/> High cholesterol or lipids (e.g. Hyperlipidemia)	<input type="checkbox"/> Diabetes
<input type="checkbox"/> High blood pressure (e.g. Hypertension)	<input type="checkbox"/> Arthritis or joint problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Depression
<input type="checkbox"/> Ulcers (stomach, esophagus)	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Headaches/migraines
<input type="checkbox"/> Hormonal related issues	<input type="checkbox"/> Eye disease (glaucoma, etc)
<input type="checkbox"/> Lung condition (e.g. asthma, emphysema, COPD)	<input type="checkbox"/> Other: Please list: _____

Current Prescription Medications:

Medication Name	Strength	Date started	How often per day

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 did you arrive at the decision to consider Bio-Identical Hormone Replacement Therapy?

Doctor                      Self                      Friend/family member                      Other

	Breakfast	Snack	Lunch	Snack	Dinner	Snack
Day 1						
Day 2						
Day 3						
Day 4						
Day 5						

What are your goals with taking HRT?

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

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PATIENT NAME: \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Hormone Replacement Therapy Patient Information Sheet**

	<b>Absent</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>
Fibrocystic breasts	_____	_____	_____	_____
Uterine fibroids	_____	_____	_____	_____
Weight gain - waist	_____	_____	_____	_____
Weight gain - hips	_____	_____	_____	_____
Heavy/irregular menses	_____	_____	_____	_____
Hot flashes	_____	_____	_____	_____
Dry skin/hair	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Sugar cravings	_____	_____	_____	_____
Night sweats	_____	_____	_____	_____
Vaginal dryness	_____	_____	_____	_____
Headaches	_____	_____	_____	_____
Irritability	_____	_____	_____	_____
Mood swings	_____	_____	_____	_____
Breast tenderness	_____	_____	_____	_____
Sleep disturbance/insomnia	_____	_____	_____	_____
Cramps	_____	_____	_____	_____
Fluid retention	_____	_____	_____	_____
Breakthrough bleeding	_____	_____	_____	_____
Fatigue - AM	_____	_____	_____	_____
Fatigue - PM	_____	_____	_____	_____
Loss of memory	_____	_____	_____	_____
Bladder symptoms/incontinence	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Harder to reach climax	_____	_____	_____	_____
Decreased sex drive	_____	_____	_____	_____
Hair loss	_____	_____	_____	_____
Cold body temp	_____	_____	_____	_____