

Bioidentical Hormone Replacement Therapy

New Patient Packet



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From a clinical management point of view, it is very useful to gain a detailed history of possible hormone deficiencies, past medical history, and previous therapy. The answers provided in the questions below will allow the pharmacist to maintain your medical history and will help in advising about current medical therapies. All information provided will be kept confidential.

Today's Date: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

DL# or SS# _____ Email address: _____

Work Phone: _____ Occupation: _____

Full time _____ Part-time _____ Retired _____ Unemployed _____ Other _____

Living Situation: Spouse _____ Partner _____ Friend(s) _____ Parent(s) _____ Children _____

Status: Married _____ Single _____ Divorced _____ Widowed _____

Do you understand what natural hormone replacement is? _____

What are your goals for Natural Hormone Replacement? _____

Doctor's Name: _____

Medical Status: Excellent_____ Good_____ Fair_____ Poor_____

Allergies: *Please check all that apply.* _____no known allergies
_____ penicillin _____ morphine _____ codeine _____ aspirin
_____ sulfa drug _____ nitrates _____ dyes _____ chemicals
_____ seasonal (pollen) allergies _____ pet allergies _____ food allergies

Other allergies: _____

Please describe the allergic reaction you experienced and when it occurred?

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 _____ Varicose Veins _____ Kidney Trouble _____ Fractures
_____ Arthritis _____ Colitis _____ Gallbladder Trouble _____ Asthma _____ Chronic Fatigue
_____ Fibromyalgia _____ Eating Disorder _____ Cancer _____ Ulcers (stomach, esophagus) _____ Epilepsy
_____ Thyroid disease _____ Headaches/migraine _____ Hormonal Related Issues _____ Eye Disease (glaucoma,etc)
_____ Lung condition (example: asthma, emphysema, COPD)

Other: Please list: _____

Habits: _____

Dietary Restrictions: _____

Do you think that you make healthy meal choices? _____

Do you get routine physical exercise? _____

What type? _____

Current Medications (how often per day) _____

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

Other (please list): _____

Nutritional/Natural Supplements: Please identify the products used.

- _____ 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.) _____

GYNECOLOGICAL HISTORY

List Hormones previously taken. Date Started / Date Stopped / Reason

ORAL CONTRACEPTIVES

Have you ever used oral contraceptives? _____ No _____ Yes

Any problems? _____ No _____ Yes

If YES, describe any problem(s). _____

PREGNANCY

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

Age at first pregnancy: _____

Any problems with pregnancies? _____

Any interrupted pregnancies? (miscarriage or abortion) _____ No _____ Yes

SURGICAL HISTORY

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

Have you had any part or whole ovary removed? _____ No _____ Yes

Have you had a tubal ligation? _____ No _____ Yes (Date) _____

LABS / EXAMS

Have you had any of the following tests performed? Check those that apply & note date of last test.

Mammography _____ No _____ Yes Date: _____

PAP Smear _____ No _____ Yes Date: _____

Pelvic Exam _____ No _____ Yes Date: _____

Results: _____

Have you ever had an abnormal pap? _____ Treatment: _____

MENSTRUAL CYCLE

Age at first Period: _____ 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: _____

Since you first began having periods, have you ever had what YOU would consider to be abnormal cycles? _____No _____Yes

If YES, please explain (such as age when this occurred, symptoms....

Are you sexually active? _____ Are you trying to get pregnant? _____

Current Birth Control Method: _____ How Long? _____

Past Birth Control and any related problems: _____

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

Number of days of flow: _____ Amount of bleeding: _____

Amount of Cramps: _____

Premenstrual Symptoms: _____

Starting and ending when: _____

Any current changes in your normal cycle: _____

Any bleeding between periods: _____ When? _____

Any pelvic pain, pressure or fullness? _____ Describe: _____

Any unusual vaginal discharge or itching? _____ Describe: _____

Treatment: _____

FAMILY HISTORY

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)_____
Diabetes _____	Family member(s)_____

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

Doctor _____ Self _____ Friend/Family _____ Other _____

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

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 Disturbance/Insomnia	_____	_____	_____	_____
Cramps	_____	_____	_____	_____
Fluid Retention	_____	_____	_____	_____
Breakthrough Bleeding	_____	_____	_____	_____
Fatigue	_____	_____	_____	_____
Loss of Memory	_____	_____	_____	_____
Bladder Symptoms	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Harder to Reach Climax	_____	_____	_____	_____

	ABSENT	MILD	MODERATE	SEVERE
Decreased Sex Drive	_____	_____	_____	_____
Hair Loss	_____	_____	_____	_____
Low Libido	_____	_____	_____	_____
Swollen Breasts	_____	_____	_____	_____
Moodiness	_____	_____	_____	_____
Fuzzy Thinking	_____	_____	_____	_____
Food Cravings	_____	_____	_____	_____
Bloating	_____	_____	_____	_____
Shortness of breath	_____	_____	_____	_____
Heart Palpitations	_____	_____	_____	_____
Frequent Yeast Infections	_____	_____	_____	_____
Vaginal Shrinking	_____	_____	_____	_____
Loss of Pubic Hair	_____	_____	_____	_____
Painful Intercourse	_____	_____	_____	_____
Weight Gain (Hips/Thighs)	_____	_____	_____	_____
Symptoms of Low Thyroid	_____	_____	_____	_____