Please complete all pages and fax back to us at: 1-800-527-0226

Specialty Compounding Pharmacy

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
___ Aspirin
___ Acetaminophen (example: Tylenol®)
___ Ibuprofen (example: Motrin IB®)
___ Naproxen (example: Aleve®)
___ Ketoprofen (example: Orudis KT®)
___ Cough suppressant (example: Robitussin DM®)
___ Antihistamine product (example: Chlor-Trimeton®)
___ Decongestant product (example: Sudafed ®)
___ Combination product (cough+cold reliever)(example: Triaminic DM®)
___ Sleep aids (exmples: Excedrin PC®, Unisom®, Sominex®, Nytol®)
___ Antidiarrheals (examples:Imodium®, Pepto Bismol®, Kaopectate®)
___ Laxatives/stool softeners (examples: Doxidan®, Correctol®, etc.)
___ Diet aids/weight loss products (example: Dexatril®)
___ Antacids (examples: Maalox®, Mylanta®)
___ Acid blockers (examples: Tagamet HB®, Pepcid C®, Zantac 75®)
___ Other (please list)
_____

PATIENT NAME: _____

___ **Nutritional/Natural Supplements: Please identify and list 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)
___ High cholesterol or lipids (examples: Hyperlipidemia)
___ High blood pressure (example: Hypertension)
___ Cancer
___ Ulcers (stomach, esophagus)
___ Thyroid disease
___ Hormonal Related Issues
___ Lung condition (example: asthma, emphysema, COPD)
___ Blood Clotting Problems
___ Diabetes
___ Arthritis or joint problems
___ Depression
___ Epilepsy
___ Headaches/migraines
___ Eye Disease (glaucoma, etc.)
___ 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 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.

Patient Name: _____

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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: _____