Confidential Medical History Form

Please return your form to the Pharmacy when you have finished.
The Pharmacist will meet with you to review your information. Thank you.

Today's Date: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____

City: _____ ST: _____ Zip: _____

Phone: _____ Email: _____

Gender: Female Male Height: _____ Weight: _____

Waist and Hip circumferences _____

	Yes or No	If YES, how often & how much?
Do you use tobacco?		
Do you use alcohol?		
Do you use caffeine?		

Water Intake _____

Food cravings Sugar _____Salt_____Carbs_____

Doctor's Name: **Address:** **Phone:**

Allergies: Please check all that apply:

___ Penicillin	___ Morphine	___ Dye allergies	___ Pet allergies
___ Codeine	___ Aspirin	___ Nitrate allergies	___ Seasonal (pollen)
___ 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 (ex:Triaminic®)
___ Aspirin	___ Sleep aids (ex:Excedrin PM®, Unisom®, Sominex®)
___ Acetaminophen (ex:Tylenol®)	___ Antidiarrheals (ex:Imodium®,PeptoBismol®, Kaopectate®
___ Ibuprofen (ex:Motrin IB®)	___ Laxatives/stool softeners (ex:Doxidan®, Correctol®)
___ Naproxen (ex:Aleve®)	___ Diet aids/weight loss products (ex:Dexatrim®)
___ Ketoprofen (ex:Orudis KT®)	___ Antacids (ex:Maalox®, Mylanta®)
___ Cough suppressant (ex:Robitussin DM®)	___ Acid blockers (ex:Tagamet HB®,Pepcid AC®,Zantac 75®)
___ Antihistimine product (ex:Chlor-Trimeton®)	___ Other (please list:)
___ Decongestant product (ex:Sudafed®	_____

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

___ Vitamins (ex: multiple or single vitamins such as B complex, E, C, beta carotene)

___ Minerals (ex: calcium, magnesium, chromium, colloidal minerals, various single minerals)

___ Herbs (ex: Ginseng, Ginkgo Biloba, Echinacea, other herbal medicinal teas, tinctures, remedies, etc)

___ Enzymes (ex: digestive formulas, papaya, bromelain, CoEnzyme Q10, etc)

___ Nutrition/protein supplements (ex: shark cartilage, protein powders, amino acids, fish oils, etc)

___ Others (ex: glucosamine, etc.)

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

___ Heart disease (ex: Congestive Heart Failure)
___ High cholesterol or lipids (ex: Hyperlipidemia)
___ High blood pressure (ex: Hypertension)
___ Cancer
___ Ulcers (stomach, esophagus)
___ Thyroid disease
___ Hormonal related issues
___ Blood clotting problems
___ Lung condition (ex: asthma, emphysema, COPD)
___ 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
1				
2				
3				
4				
5				
6				

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, please describe below.

How many pregnancies have you had? How many children? ages:

Any interrupted pregnancies? No Yes

Patient Name: SS#:

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)
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 the 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 consider to be abnormal cycles?
No Yes Date:

Please
explain: _____

When was your last period? _____
How long did it last? _____
Age of first Menses:
Do you have, or did you ever have Premenstrual Syndrome (PMS)? _____ No _____ Yes
If YES, please explain symptoms:

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?

Patient Name:	SS#:

Hormone Replacement Therapy Patient Information Sheet

Name _____

Have you experienced any of the following symptoms recently? Please circle the number that best describes your experiences with one being Extremely Mild and ten being Extremely Severe.

Sleep Disruptions	1	2	3	4	5	6	7	8	9	10
Fatigue	1	2	3	4	5	6	7	8	9	10
Vaginal Dryness	1	2	3	4	5	6	7	8	9	10
Irritability	1	2	3	4	5	6	7	8	9	10
Nervousness	1	2	3	4	5	6	7	8	9	10
Breast Tenderness	1	2	3	4	5	6	7	8	9	10

Hot Flashes	1	2	3	4	5	6	7	8	9	10
Dry Skin	1	2	3	4	5	6	7	8	9	10
Mood Swings	1	2	3	4	5	6	7	8	9	10
Arthritis	1	2	3	4	5	6	7	8	9	10
Loss of Recent Memory	1	2	3	4	5	6	7	8	9	10
Weight Gain	1	2	3	4	5	6	7	8	9	10
Decreased Sex Drive	1	2	3	4	5	6	7	8	9	10
Depression	1	2	3	4	5	6	7	8	9	10
Fluid Retention	1	2	3	4	5	6	7	8	9	10
Headaches	1	2	3	4	5	6	7	8	9	10
Night Sweats	1	2	3	4	5	6	7	8	9	10
Hair Loss	1	2	3	4	5	6	7	8	9	10
Harder to Reach Climax	1	2	3	4	5	6	7	8	9	10
Bladder Symptoms	1	2	3	4	5	6	7	8	9	10
Other:	1	2	3	4	5	6	7	8	9	10
Dry eyes	1	2	3	4	5	6	7	8	9	10
Constipation	1	2	3	4	5	6	7	8	9	10

Please bring all lab work and vitamins with you to your appointment.
Please make list of all stressors –start 2 years prior to when your symptoms started.
Bone density test yes no date of last test
Date of first test
Normal body temperature before rising _____ norm 97.8-98.2
(if menstruating take day 2-4 of cycle.) Needed if answer yes to weight, hair, fatigue, depression or constipation.