Confidential Hormone Evaluation Form

This document can be printed.

Please fill out the information completely, then fax or send to:

Hazle Compounding
Attn: Lori Ann Gormley, R.Ph., Certified Menopause Educator
7 N. Wyoming Street
Hazleton, PA 18201
Fax: 570-454-4532 or 800-400-8764

Our Menopause Educator will then contact you to schedule your hormonal consultation either in person or by phone.

Today's Date: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____

City: _____ ST: _____ Zip: _____

Home Phone: _____ Work Phone: _____Email: _____

Gender: Female Male Height: _____ Weight: _____

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

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
- ____ Aspirin
- ____ Acetaminophen (ex:Tylenol®)
- ____ Ibuprofen (ex:Motrin IB®)
- ____ Naproxen (ex:Aleve®)
- ____ Ketoprofen (ex:Orudis KT®)
- ____ Cough suppressant (ex:Robitussin DM®)
- ____ Antihistamine product (ex:Chlor-Trimeton®)
- ____ Decongestant product (ex:Sudafed®
- ___ Combination product, cough+cold reliever (ex:Triaminic®)
- ___ Sleep aids (ex:Excedrin PM®, Unisom®, Sominex®)
- ___ Antidiarrheals (ex:Imodium®,PeptoBismol®, Kaopectate®
- ___ Laxatives/stool softeners (ex:Doxidan®, Correctol®)
- ___ Diet aids/weight loss products (ex:Dexatrim®)
- ___ Antacids (ex:Maalox®, Mylanta®)
- ___ Acid blockers (ex:Tagamet HB®,Pepcid AC®,Zantac 75®)
- ___ Other (please list:)

_____

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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.)

_____

Are you currently using any over the counter products for the relief of hormonal symptoms (examples: herbs, homeopathic remedies, estrogen and or progesterone creams)?

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: _____

Do you experience any of the following?	Yes	No	Sometimes
1. indigestion, gas heartburn, cramping	_____	_____	_____
2. poor appetite, nausea, heartburn	_____	_____	_____
3. constipation or diarrhea	_____	_____	_____
4. diet changes for bowel integrity	_____	_____	_____
5. crave sweets	_____	_____	_____
6. allergies – food or environmental	_____	_____	_____
7. muscle/joint cramping or soreness	_____	_____	_____
8. eyes sensitive to bright light, stress	_____	_____	_____
9. flashes, sparks or floaters in eyes	_____	_____	_____
10. headaches	_____	_____	_____
11. poor circulation, hands, feet	_____	_____	_____
12. toxic metal exposure – work/living	_____	_____	_____
13. emotional stress, anxiety, depression	_____	_____	_____
14. parasitic or bacterial infections	_____	_____	_____
15. special or vegetarian diet	_____	_____	_____
16. fatigue	_____	_____	_____

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

Bone Type: _____Androgenic (larger upper body compared to lower body)

_____Estrogenic (Smaller upper body compared to lower body)

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? _____

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 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? _____

Do you have, or did you ever have Premenstrual Syndrome (PMS)? No Yes

_____ _____

If YES, please explain symptoms:

_____

Hormone Replacement Therapy Patient Information Sheet

Please rate the following symptoms

	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	_____	_____	_____	_____

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

Doctor _____ Self _____ Friend/Family Member _____ Seminar _____
Books/Article _____ Another patient _____ Other _____

If you were referred to Hazle Compounding, who referred you?

What are your goals with taking BHRT?

Question Documentation Form

Please list any other pertinent information that you feel we should know about. Also, please write down any questions you may have about Prescription Bio-Identical Hormone Replacement Therapy (Rx BHRT), or other medications. Any other questions that come up as you read through the materials you have received can be listed below. Our Certified Menopause Educator will then discuss this information with you.

1.

2.

3.

This information is strictly confidential and is in accordance with all HIPPA regulations.