Tri-State Compounding Pharmacy

TRI-STATE COMPOUNDING PHARMACY

Confidential Hormone Evaluation Female

MEDICAL HISTORY **Today's Date: _____**

Name: _____ **Birth date:** _____/_____/_____ **Age:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Mobile Phone:** _____

E-Mail Address: _____

Gender: ☐ **Male** ☐ **Female** **Height:** _____ **Weight:** _____

			If Yes, 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:**
(Please also list type of practice: Family practice, OB/GYN, other)
1) _____
2) _____
3) _____
4) _____

Allergies: *Please check all that apply.*

☐ **Penicillin**	☐ **Morphine**	☐ **Dye allergies**	☐ **Pet allergies**
☐ **Codeine**	☐ **Aspirin**	☐ **Nitrate allergy**	☐ **Seasonal allergies**
☐ **Sulfa drugs**	☐ **Food Allergies, if yes please specify:** _____		
☐ **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/Circle all that apply.

☐ **Pain Reliever:**
- ❍ **Aspirin**
- ❍ **Acetaminophen (Tylenol®)**
- ❍ **Ibuprofen (Motrin®)**
- ❍ **Naproxen (Aleve®)**
- ❍ **Ketoprofen (Orudis KT®)**

☐ **Cough suppressants: Robitussin DM®, Others:**_____

☐ **Combination products: (cough + cold relievers) Triaminic DM®, Nyquil®, Other:** _____
_____

☐ **Antidiarrheals: Imodium ®, Pepto Bismol®, Kaopectate®, Other:** _____

☐ **Laxatives/Stool Softeners: Doxidan®, Correctol®, Others:** _____

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Over-The-Counter (OTC) Issues Continued:

- ☐ **Antihistamine products: Chlor-Trimeton®, Others:** _____
- ☐ **Decongestant product: Sudafed®, Others:** _____
- ☐ **Sleep aids: Excedrin PC®, Unisom ®, Sominex® Nytol®, Other:**_____
- ☐ **Diet aids/Weight loss products: Dexatril®, Others:** _____
- ☐ **Antacids: Maalox®, Mylanta®, Tums®, Others:** _____
- ☐ **Acid blockers: Tagamet HB®, Pepcid C®, Zantac 75®, Prilosec OTC®, Others:** _____
- ☐ **Others:** (Please list) _____

Nutritional/Natural Supplements: *Please check/circle and list the products you are using.*

☐ **Vitamins:** Multi-Vitamin, Multi-Vitamin with Iron, B Complex, Vitamin E, Beta-Carotene, Others: _____

☐ **Minerals:** Calcium, Magnesium, Chromium, Colloidal minerals, Others: _____

☐ **Herbals:** Ginseng, Gingko Biloba, Echinacea, Medicinal teas, Tinctures, Remedies, Others:_____

☐ **Enzymes:** Digestive formulas, Papaya, Bromelain, CoEnzyme-Q10, Others: _____

☐ **Nutrition/Protein Supplements:** Shark cartilage, Glucosamine Chondroitin, Fish Oil, Protein Powers, Amino Acids, Others: _____

☐ **Others:** _____

Diet: *Please list your intake on a typical day.*

Breakfast:_____
Lunch:_____
Dinner:_____
Snacks:_____
Desserts:_____

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

- ☐ **Heart disease (example: Congestive Heart Failure)**
- ☐ **High Cholesterol or lipids (example: Hyperlipidemia)**
- ☐ **High Blood Pressure (example: Hypertension)**
- ☐ **Cancer, if yes please specify what type:** _____
- ☐ **Depression**
- ☐ **Ulcers: Stomach or Esophagus**
- ☐ **Headaches/ Migraines**
- ☐ **Hormonal Related Issues**
- ☐ **Lung condition: Asthma, Emphysema, COPD**
- ☐ **Blood Clotting Problems**
- ☐ **Diabetes**
- ☐ **Arthritis or joint problems**
- ☐ **Seizure disorder (example: Epilepsy)**
- ☐ **Thyroid disease (example: Overactive or Underactive Thyroid)**
- ☐ **Eye disease (example: glaucoma, etc.)**
- ☐ **Other:** Please list._____

Current Prescription Medications:

Medication Name	Strength	Date Started	How often per day
1)			
2)			
3)			
4)			
5)			
6)			
7)			

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Preferred Dosage Forms: Please check any of the following.

☐ **Topicals: Ointments/Creams** ☐ **Tablets, Capsules, or Lozenges**
☐ **Solutions or Suspensions** ☐ **Suppositories**

List Hormones Previously Taken **Date Started** **Date Stopped** **Reason**

1)_____
2)_____
3)_____

Have you ever used oral contraceptives before? ☐ **Yes** ☐ **No**
Have you ever experienced any problems with these? ☐ **Yes** ☐ **No**
If Yes, please specify: _____
_____

How many pregnancies have you had? ☐ **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6+**

How many children? ☐ **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6+**

Any interrupted pregnancies? ☐ **Yes** ☐ **No**

Have you had a hysterectomy? ☐ **Yes** ☐ **No**
If Yes, date of surgery? _____
Have you had ovaries removed? ☐ **Yes** ☐ **No**

Have you had tubal ligation? ☐ **Yes** ☐ **No**
If Yes, date of surgery? _____

Do you have a family history of the following? *Please check all that apply.*

☐ **Uterine Cancer** **Family Members diagnosed:** _____
☐ **Ovarian Cancer** **Family Members diagnosed:** _____
☐ **Fibrocystic Breast** **Family Members diagnosed:** _____
☐ **Breast Cancer** **Family Members diagnosed:** _____
☐ **Heart Disease** **Family Members diagnosed:** _____
☐ **Osteoporosis** **Family Members diagnosed:** _____

Have you had any of the following tests performed? *Check all that apply, and please note the last date of each test.*

☐ **Mammography** ☐ **Yes** ☐ **No** **If Yes, date completed:** _____
☐ **PAP Smear** ☐ **Yes** ☐ **No** **If Yes, date completed:** _____

Date of last Doctor visit: (MM/DD/YY)_____/_____/_____
Type of Doctor last seen: (example: Family doctor, OB/GYN, etc) _____

Since you first began having periods, have you ever had what YOU would consider to be abnormal cycles? ☐ Yes ☐ No Date of onset:_____
If Yes, please explain (such as age when this occurred, symptoms, etc…): _____
_____
_____
_____

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When was your last period? _____
How many days did it last? _____

Do you have, or did you ever have Premenstrual Syndrome (PMS)? ☐ Yes ☐ No
If Yes, please explain symptoms: _____
_____
_____

How did you arrive at the decision to consider Bio-Identical Hormone Replacement Therapy (BHRT)? Please check the one of the following.
☐ **Doctor** ☐ **Self** ☐ **Family Member/Friend** ☐ **Other:** _____
What are your goals with taking BHRT?
1)_____
2)_____
3)_____
4)_____

Please write down any questions you have about Bio-Identical Hormone Replacement Therapy (BHRT):_____
_____
_____
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