RYE BEACH PHARMACY'S
CONFIDENTIAL HORMONE EVALUATION

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:

_____
_____
_____

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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.

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Patient Name: _____

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	_____	_____	_____	_____

Consultation Fee: 1 Hr - $150 / additional time will be prorated

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Rye Beach Pharmacy

Robert M. GiaQuinto
R.Ph./President

PATIENT INFORMATION

NAME:_____ PHONE #_____

ADDRESS:_____

CITY:_____ STATE:_____ZIP:_____

D.O.B._____ AGE:_____ SEX: MALE or FEMALE (CIRCLE ONE)

MARITAL STATUS: SINGLE, MARRIED, DIVORCED OR WIDOW (CIRCLE ONE)

SS#:_____ REFERRED:_____

PATIENT CONSENT

I understand that balancing the endocrine (hormonal) system is an essential element in achieving a better state of health. This goal can only be achieved through a professional triage consisting of; a certified hormone specialist, a licensed medical doctor and me, the patient.

I understand that Rosella Menta, R.Ph is not a medical doctor, but a hormone specialist. Rye Beach Pharmacy and all such representatives of which, only assess disease states and will not diagnose diseases or prescribe medications. In doing so, may use unconventional approaches to disease management that some healthcare practitioners may not agree with.

I understand that hormonal balance is our goal which will take time and cooperation between qualified practitioners and I. There might be a need to adjust strengths of medications used, dosage forms or a change in treatment, which can take 4 to 6 months or longer if necessary.

Print:_____ Signature:_____

Date:_____