Hormone Self Assessment Questionnaire

1802 N. Monroe
Spokane, WA 99205
Phone: 509-343-6252 or 888-550-1566

Email: chudek@riverpointrx.com
Website: www.riverpointrx.com
Fax: 509-343-6251 or 888-567-5937

Dear Patient,
I have designed this questionnaire to learn more about you in order to assist you in achieving your optimum health. I believe that a woman's lifestyle, habits and other characteristics are a vital part of her health assessment and your participation in this process will help me better evaluate your test results, risk factors and preventive needs. This information will be placed in a secure file and will **NOT** be shared with anyone ***including your insurance company***. If you feel uncomfortable answering any of the questions, please feel free to leave the answer blank.

Patient Name: ______________________________Date of Birth: ________________ Today's Date: ________________

Address: ________________________________City: ________________________State: _________ZIP:____________

Phone: (Home)_____________________________(Work)_____________________________(Cell)__________________

Physicians name:________________________________ RX Insurance:____

Insurance Group # _______________________________ ID# _______________________BIN #________________________

Allergies: ____Food ____Seasonal ____Drugs (please list)____

Other: ____

Over the Counter Product Use

Please check all products that you use whether occasionally or regularly.

___Aspirin __Acetaminophen (ex. Tylenol®) ___Ibuprofen (ex. Motrin IB®) ___Naproxen (ex. Aleve®)

___Ketoprofen (ex. Orudis KT®) ___Cough Suppressant (ex. Robitussin DM®) ___Antihistamine

___Decongestant (ex. Sudafed®) ___Combination Cough & Cold Products ___Sleep Aids (ex. Nytol®)

___Laxatives/stool softeners ___Diet Aids, Weight Loss products ___Antacids (ex. Maalox®)

Acid Blockers (ex. Tagamet HB®, Pepcid AC®) Others:____

Nutritional Supplements:

Please list any vitamins, minerals, herbs, enzymes, nutrition, protein or other supplements that you take on a regular or occasional basis:

____
____
____

Current Prescription Medications:

Medication Name	Strength	Date Started	How often per day

List Hormones Previously Taken:

Name	Strength	Date Started	Date Stopped	Reason

Have you ever used oral contraceptives? ____ **No** ___**Yes**
Any Problems? ____ **No** ___**Yes**
If YES, describe problems:

____
____

Does you anyone in your family have, or has had, any of the following:

Breast Cancer ____________ Family Member(s) ________________________
Ovarian Cancer ____________ Family Member(s) ________________________
Uterine Cancer ____________ Family Member(s) ________________________
Fibrocycstic Breast _________ Family Member(s) ________________________
Heart Disease ____________ Family Member(s) ________________________
Osteoporosis _____________ Family Member(s) ________________________
Diabetes ________________ Family Member(s) ________________________

Medical History

General Health: Excellent _______ Good _____ Fair _____ Poor _____
Height: _______________ **Weight:** ________________

Please check all that apply:

Breast Cancer ________ Ovarian Cancer ________ Uterine Cancer ________
Heart Disease ________ Diabetes _____________ High Blood Pressure ________
Osteoporosis _________ Stroke _______________ Endometriosis ________
Fibroids ____________ Blood Clots ___________ Impaired Liver Function _________
Fibrocystic Breast _____ **Other** ______________________________________

Reproductive Health

Menstrual Periods:
None ____________ Regular ___________Irregular (describe)______________________________
Age of first period ______ Age of last period _____

Have you ever been pregnant? ___No ___Yes # of children _________
Have you ever had infertility treatments? ___No ___Yes Describe ____________
Any interrupted prenancies? ___No ___Yes Describe ____________
Have you had a hysterectomy? ___No ___Yes Date _______________
Reason:____
Ovaries Removed? ___No ___Yes Date ______________
Have you had a tubal ligation? ___No ___Yes Date _______________
Have you had a D & C? ___No ___Yes Date _______________
Have you had an ablation? ___No ___Yes Date _______________
Date of most recent Pap Test: ____________________________ Results:______________
Date of last cholesterol check: ____________________________ Results:______________
Have you ever had a mammogram: __________ Date ___________ Results:______________
Have you ever had a bone density scan: ______ Date ___________ Results:______________

Lifestyle Information Form-Optional

Physical Activity

1. In the past year, how often have you engaged in physical activity?
   ____ Regularly (3-4 times/week)
   ____ Semi-regularly (1-2 times/week)
   ____ Sporadic (1-2 times/month)
   ____ None

2. What types of physical activity do you consider fun?
   ____
   ____

3. What are your personal barriers to exercise? ______________________________________
   ____

4. What physical activity have you been successful with in the past (liked and participated in regularly) ?
   ____

5. How do you think your weight affects your daily activities? ___________________________

Support

1. Do you feel any family, friends, or co-workers have negative feelings toward your efforts at physical activity? ____

2. Is your significant other or a close friend involved in any regular physical activity? __________

Occupation/Leisure

1. What is your present occupation? ____

2. Does your occupation require much activity? _____________________________________

3. What are your leisure activities? ____

Stressors

1. What types of things make you feel stressed? ____________________________________

2. How do you deal with stress normally? ____

3. Do you feel that exercise would be useful to help manage stress? _____________________

Expectations

Specifically what you would like to accomplish through your fitness program during the next:

One month ____

4 months ____

1 year ____

To what degree do you experience the following?

	None	Slightly	Moderate	Severe	Extreme
Difficulty Concentrating/Loss of Memory					
Can't Sleep					
Depressed or Unhappy					
Anxious					
Headaches					
Moodiness/Emotional Swings					
Painful or Swollen Breasts					
Weight Gain/Bloating					
PMS					
	None	**Slightly**	**Moderate**	**Severe**	**Extreme**
Night Sweats					
Difficulty Remembering Things					
Hot Flashes					
Vaginal Dryness					
Dry Hair/Skin					
Urine Leakage (Incontinence)					
Frequent Urinary Tract Infections					
Inability to Reach Orgasm					
Painful Intercourse					
	None	**Slightly**	**Moderate**	**Severe**	**Extreme**
Lack of Sexual Desire					
Fatigue/Loss of Energy					

What are your goals for Bio-Identical HRT ?

____

____

____

Waiver

I herby release Riverpoint Pharmacy and all of its employees and pharmacists from any and all liability whatsoever associated or connected with my Natural (Bio-Identical) Hormone Replacement consultations and/or use of Natural (Bio-Identical) Hormone Replacement. I hereby state that I am an adult and that I am aware of the potential side effects associated with Natural (Bio-Identical) Hormone Replacement. I hereby agree to answer truthfully all of the medical questions on my questionnaire.

I understand that no doctor, nurse, pharmacist, or administrative personnel can guarantee that Natural (Bio-Identical) Hormone Replacement will provide the results I seek. I hereby release Riverpoint Pharmacy and all of its employees from any and all liability whatsoever associated with any adverse effects I may suffer from my use of Natural (Bio-Identical) Hormone Replacement.

I am participating in this program at my own choice, and I assume all responsibility for my use of Natural (Bio-Identical) Hormone Replacement. I fully understand that it is my responsibility to have an annual physical examination, including any suggested laboratory tests to ensure that I have no medical conditions that might make Natural (Bio-Identical) Hormone Replacement inappropriate for my condition.

Signed ____ **Date** ____________

Billing Information

- Your credit card will be billed for the cost of the prescription and if shipped by mail the shipping will be at no extra charge.
- Your order will be shipped by USPO or Federal Express unless otherwise specified.
- We accept Master Card, Visa, American Express, Discover, Checks, money orders and cash.

Riverpoint Pharmacy honors many prescription insurance plans. Please send a copy of the front and back of your insurance plan membership card or call this information into us at **(509) 343-6252 or (888) 550-1566.**

Your name as it appears on your credit card:_________________________
Credit Card Number: ____
Expiration Date (mm/yy): ____

Chose your shipping method:

- **USPS …… $6.00** (generally delivered the next day in the Spokane area)
- **Priority Mail ……..$15.00**
- **2nd Day……$25.00**
- **Overnight…$35.00**
- **Overnight on ice $55.00**

_________Please initial if you agree to have you package left at your home without a signature. Riverpoint Pharmacy assumes no liability for lost, stolen or damaged packages.

Please let us know how you heard about Bio-Identical Hormone Replacement Therapy:

Advertisement: ____________________Newspaper: ______________
Books: _____________________________Magazine: ________________
Healthcare Provider: _______________Other: ____________________

All Information can be faxed, mailed, or scanned and emailed to Riverpoint Pharmacy at:

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If you have any questions call us between 8:30am and 5:00pm PacificTime at**: (509) 343-6252 or (888) 550-1566.**