CONFIDENTIAL HORMONE EVALUATION
MEDICAL HISTORY

Today's Date: _____

Name: _____ **Birth date:** _____ **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 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.

Also, circle the product, if listed or write the name below- Vitamins and supplements are on the next page

___ 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®)
___ 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®)
___ Decongestant product (example: Sudafed ®)
___ Other (please list _____

_____
_____

Nutritional/Natural Supplements: Please identify (circle or write in the name) and list the products you are using- please add the dose:

___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 (narrow hips, fat carried in abdomen, etc.)
___ Estrogenic (broader hips, fat carried in hips, thighs, buttocks, etc.)

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 ___No ____Yes Family member(s) _____
Ovarian Cancer ___No ____Yes Family member(s) _____
Fibrocystic breast ___No ____Yes Family member(s) _____
Breast Cancer ___No ____Yes Family member(s) _____
Heart Disease ___No ____Yes Family member(s) _____
Osteoporosis ___No ____Yes 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:

_____
_____
_____

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

___Doctor/Provider ___ Self _____Friend/Family Member ____Other

PATIENT NAME: _____

What are your goals with taking BHRT?

____
____
____
____

Please write down any questions you have about Bio-Identical Hormone Replacement Therapy.

____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____

Patient Name: ______________________________

PLEASE RETURN ALL COMPLETED FORMS AT LEAST 3 DAYS PRIOR TO YOUR CONSULTATION. RETURN VIA THE FOLLOWING:

1. Fax: 970-224-3113
2. Email: bhrt@gooddaypharmacy.com
   (Note: email does not protect your private health information)
3. Mail or deliver to:
   Good Day Pharmacy - BHRT
   2001 S. Shields St, Bldg D
   Ft. Collins, CO 80526

Call our consultant at 970-224-1212 with any concerns or questions.