LEGACY COMPOUNDING

Address: 2422 Danville Road Suite H Decatur AL 35603
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CONFIDENTIAL HORMONE EVALUATION

Today's date: _____

Name: _____ Birth date: _____ Age: _____

Address: _____

Phone: _____ Email: _____

Height: _____ Weight: _____ Desired Weight: _____

		How often and how much?
Do you use tobacco?	YES or NO	_____
Do you use alcohol?	YES or NO	_____
Do you use caffeine?	YES or NO	_____
Do you exercise?	YES or NO	_____

Allergies: Please list any allergies and describe the reaction that occurred.

Drugs: _____

Foods: _____

Other: _____

Over-the-counter Medication History: Please list non-prescription medications that you are taking. (**Include** vitamins, herbals, and supplements):

_____

_____

_____

Medical Conditions/Diseases: Please list any conditions/diseases that you have been diagnosed with or suffer from. (Examples include: Heart disease, high blood pressure, depression, ulcers, arthritis, insomnia, etc).

_____

_____

_____

Current Prescription Medications (**excluding hormones**):

Medication Name and Strength	Date Started	How often per day
_____		
_____		
_____		

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Patient Name: _____

List Hormones Previously Taken: Date Started Date Stopped Reason

_____

_____

Have you ever used oral contraceptives (birth control)? _____

If you experienced any problems, please describe:

_____

_____

How many pregnancies have you had? _____ How many children? _____

Any interrupted pregnancies? YES or NO

If yes, please explain: _____

Have you had a tubal ligation: YES or NO

If yes, date of surgery: _____

Have you had a hysterectomy: YES or NO

If yes, date of surgery: _____

Reason: _____

Have you had your ovaries removed: YES or NO if so, how many: 1 or 2

Do you have a family history of any cancers or osteoporosis? Please list the family members:

_____

_____

Have you had any of the following tests performed?

Mammography: YES or NO Date: _____

Results:_____

PAP smear: YES or NO Date: _____

Results:_____

Bone Density: YES or NO Date: _____

Results: _____

What age did your period start? _____ How many days is / was your cycle (Example 28 days) _____

Is/was your menstrual flow heavy or light? _____ Any clots? YES or NO

Have you ever had what YOU would consider to be abnormal cycles? YES or NO

Explain:_____

_____

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

Do you or have you ever suffered from Premenstrual Syndrome (PMS) symptoms? YES or NO

Explain: _____

Hormone Symptoms Evaluation

Patient Name: _____

Select the symptoms that apply to you.

	None	Mild	Moderate	Severe
Fibrocystic Breast	_____	_____	_____	_____
Weight Gain	_____	_____	_____	_____
Heavy/ Irregular periods	_____	_____	_____	_____
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 Climax	_____	_____	_____	_____
Decreased Sex Drive	_____	_____	_____	_____
Hair Loss	_____	_____	_____	_____

Patient Name: _____

What problems do you want to resolve with hormone replacement therapy?

1.)_____
_____
_____
_____
_____

2.)_____
_____
_____
_____
_____

3.)_____
_____
_____
_____
_____

Doctor that we should contact for this therapy:

Doctor's Name: _____ Phone: _____

Address: _____

***Please include <u>a copy of all relevant lab work</u>,**
Especially hormone levels that you have recently obtained.*

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Hormone Evaluation Follow-Up Questions

What are your chief complaints?

Current hormone replacement medications?

How long have you been on the above medications?

Any concerns with these current medications?

Have you changed these medications? Why?

Have you been compliant with BHRT? If not, why?

Have you had any hormone levels taken? (Saliva, urine, blood)