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Date: _____

# Female Information and Health Summary

Name_____ Date of Birth _____

Address_____City/State/ZIP_____

Home Phone (_____)-_____-_____ Cell (_____)-_____-_____ Fax (____)-_____-_____

Email address _____Who referred you to us? _____

Please List Your Healthcare Providers & Indicate Which Doctor to Contact Regarding Hormone Therapy

Name_____ Name_____
Specialty _____ Specialty_____
Address _____ Address_____
Phone _____ Phone_____
Fax_____ Fax_____

Insurance Information:

Plan Name_____ BIN# _____PCN#_____
ID# _____ Pharmacy Group#_____
Who is the main cardholder? _____ Your member #_____

Height: _____ Weight: _____

Any Known Medication Allergies_____

Please List Any Medications You Are **CURRENTLY** Taking, **Including Hormones (With Strengths),** Vitamins, Natural Supplements, or Non-Prescription Medications:

_____ _____
_____ _____
_____ _____
_____ _____

Please List Any **PREVIOUS** Hormones Taken, Doses, Any Side Effects, and How Long Ago They Were Discontinued:_____

Have You Tried Alternative Therapies or Taken Any Herbal or Homeopathic Products?

_____

_____

Is Your **Diet:** 1 Bad 2 Fair 3 Good 4 Very Good (please circle)

**Exercise:** Type of Activity, How Frequent, and For How Long?

_____

## Employer and Job Title _____

**Circle Your Perceived Stress Level:** 1 None 2 Mild 3 Moderate 4 Severe 5 Extremely Severe

## Family History

**Please Check All That Apply:**

___ Cancer (type)

- ___ Breast_____ Relationship to You_____
- ___ Uterine_____ Relationship to You_____
- ___ Ovarian_____ Relationship to You_____
- ___ Other_____ Relationship to You_____

___ Diabetes; type_____ Relationship to You_____

___ Heart Disease_____ Relationship to You_____

___ Osteoporosis_____ Relationship to You_____

___ Alzheimer's Disease_____ Relationship to You_____

___ Thyroid Disease_____ Relationship to You_____

## Past or Present Medical Conditions

**Please check all that apply:**

| | | |
|---|---|---|
| ___ Asthma | ___ Fibromyalgia | ___ Fractures _____ |
| ___ Cancer (type:_____ | ___ Arthritis | ___ Epilepsy |
| ___ Depression | ___ Varicose Veins | ___ Liver Disorder |
| ___ Diabetes (type:_____) | ___ Kidney Disorder | ___ Eating Disorder |
| ___ Headaches/Migraines | ___ Thyroid Disorder | ___ Ulcers |
| ___ Heart Condition _____ | ___ High Cholesterol | ___ Chronic Fatigue Syndrome |
| ___ High Blood Pressure | ___ Clotting Disorder | ___ Other _____ |
| ___ Osteoporosis/Osteopenia | ___ Gallbladder Disease | |

## Gynecological History

- Have You Had a Hysterectomy? ___Yes ___No If Yes,When?_____
- Have Your Ovaries Been Removed? ___Yes ___No If Yes, When? _____
- Have You Ever Had a Tubal Ligation? ___Yes ___No If Yes, When?_____
- Have You Ever Had an Abnormal Pap? ___Yes ___No If Yes, When?_____
- Do You Perform Self-Breast Exams? ___Yes ___No How Often?_____

## Obstetrical History

- Are You Sexually Active? ___Yes ___No
- Are You Trying to Get Pregnant? ___Yes ___No
- Current Method of Birth Control? _____ ____How Long ?_____
- Past Method of Birth Control &/or Any Problems? _____
- Have You Ever Had Children? ___Yes ___No
- Number of Pregnancies_____ Deliveries_____ Multiple Births_____

## Have you ever had . . . (check all that apply)

___ Sexual Problems
___Cervical Dysplasia
___ Vaginal Dryness
___ Vaginal Infections
___ Pelvic Infections
___ Increased Facial/Body Hair Growth
___Cervical Cancer
___ Painful Intercourse
___Uterine Fibroids
___Lack of Energy
___HSV (vaginal herpes)
___Polycystic Ovary Syndrome
___ Lack of Sex Drive
___Ovarian Cysts
___Breast Fibroids
___ HPV(vaginal warts)
___ Inability to Reach Climax

## Menstrual History

Describe your menstrual cycle:

___ Regular ___ Irregular ___ Sporadic
___ Light ___ Heavy ___ No periods

Have You Missed Periods Altogether? ___Yes ___No

When Was Your Last Period? _____ How Long is Your Cycle?_____

Do You Have Bleeding Between Periods? ___Yes ___No

Have You Ever Taken Hormones Before? ___Yes ___No

How Did You Become Interested in Bio-Identical Hormones?

_____

_____

_____

_____

_____

**Prescription Cost Acknowledgment** – *initial below*

To best address your individual symptoms and current hormone levels, the pharmacist may recommend between **1 and 3 separate prescription**s. Most of the time compounded prescriptions are not covered by insurance. The out-of-pocket cost for **each** prescription is approximately **$55-60 per month.**

_____ I am aware that my monthly cost may be between $55 and $180 per month. If cost savings is a priority, I will discuss this with my pharmacist before my chart is reviewed so that she can best recommend therapy to my doctor.

**Dosage Forms –** *indicate below*

The safest and most effective route of administration for (some of) our hormones is in a topical route that avoids what we call "the first pass effect", which occurs when we take any medications by mouth. For this reason, most hormones are administered either in a topical cream (applied to inner thigh) or a troche (lozenge dissolved between cheek and gum over a 10-15 minute period). Please mark below if you have a preference of dosage form. If none are specified, we will suggest a topical cream.

**_____ topical cream  _____ troche  _____ no preference**

## Current Symptoms

**Please check ALL symptoms below that apply** (this is very important to the evaluation process)

Symptoms of **low Progesterone**?

__ Swollen Breasts
__ Anxiety/Irritability
__ Irregular menses
__ Infertility
__ Weight Gain
__ Mood Swings
__ PMS
__ Joint Pain
__ Food Cravings
__ Headaches ___per week
__ Cramping
__ Acne
__ Low Sex Drive
__ Depression
__ Fuzzy Thinking
__ Low Energy

Symptoms of **low Estrogen**?

__ Hot Flashes
__ Dry Skin
__ Foggy Thinking
__ Painful Intercourse
__ Night Sweats ___per week
__ Yeast Infections
__ Bone Loss
__ Insomnia ___per week
__ Heart Palpitations
__ Low Sex Drive
__ Vaginal Dryness/Atrophy
__ Memory Lapses
__ Depression
__ Headaches ___per week

Symptoms of **low Testosterone?**

__ Depression
__ Joint Pain
__ Heart Palpitations
__ Fibromyalgia
__ Urinary Incontinence
__ Low Sex Drive
__ Memory Lapses
__ Vaginal Dryness
__ Low Energy
__ Bone Loss
__ Muscle Weakness
__ Thinning Skin

Other Symptoms_____

**Top 3 Symptoms You Would Like Resolved**

1. _____
2. _____
3. _____

## Circle the Number That Best Describes the DEGREE of Symptom Intensity You Have Experienced Over the Past Month(s)

| None | Mild | Moderate | Severe |
|---|---|---|---|
| **0** | **1** | **2** | **3** |

1. Hot Flashes, Perspiration, and/or Chilly sensations?

   0 1 2 3

2. Insomnia or Restless, Fragmented Sleep?

   0 1 2 3

3. Irritability, Feeling Anxious or Apprehensive?

   0 1 2 3

4. Feeling of Depression and Unhappiness and/or Being Miserable Without Obvious Reason?

   0 1 2 3

5. Sensations of Dizziness or Swimming in the Head?

   0 1 2 3

6. Feeling of Weariness of Mind and Body Associated with Desire for Rest; Disinclination to make Further Efforts?

   0 1 2 3

7. Pain of Any Kind Affecting Joints or Muscles?

   0 1 2 3

8. Headaches of Any Kind (Tension, Migraine, etc)?

   0 1 2 3

9. Quickening or Acceleration of Heartbeat or Fluttering/Pounding Heartbeat in a Sitting or Resting Position?

   0 1 2 3

## Have you ever had . . .

| Never | Infrequently | Sometimes | Most of Time | Always |
|---|---|---|---|---|
| **0** | **1** | **2** | **3** | **4** |

1. Vaginal Burning or Itching?

   0 1 2 3 4

2. Painful Urination or Increased Frequency or Urination?

   0 1 2 3 4

3. Leaking of Urine When Coughing, Laughing, Sneezing, or On Hard Work?

   0 1 2 3 4

4. Leaking of Urine When Walking, Running, Climbing Steps, or On Light Work?

   0 1 2 3 4

5. Leaking of Urine, Regardless of Activity, Even When In a Lying Position?

   0 1 2 3 4

# BHRT Compounded Medication Agreement

**Please Initial**

_____ I authorize the staff at The Medicine Shoppe to review my information and use this information to contact my physician's office for approval of BHRT compounded medication(s).

_____ I understand the importance of regular preventative screening(s) by my physician (e.g. mammogram, pap smear, blood work, etc.) in order to use BHRT properly and responsibly.

_____ I understand that I will be required to give a credit card number for prepayment prior to my first fill of any compounded medication(s) and this card will only be charged subsequently if I request it to be used **OR** fail to pick up a refill that I have requested to have made.

_____ I understand that every individual's body is different, and while the pharmacist will do their best to provide symptom relief with my first prescription, it is normal to require further dose modifications as my body adjusts to the hormones. Each dose adjustment will require a new prescription from my physician, and extra time needs to be allotted to have this done.

_____ I understand that if I have had 2 or 3 dose changes already, it may be necessary to get labs done to see how my body is responding and to rule out other existing health issues.

_____ I understand that I will need to give any dose adjustment on my hormones 4 to 6 weeks for my body to adjust before requesting further adjustments to be made.

_____ I understand that I need to call refills in **at least 5 business days (Monday-Friday)** to avoid running out before my compound is ready **(or longer if the doctor needs to be called for refills or if I ask for it to be mailed).** Most of the time it will only take 2 or 3 days, however, some compounds take longer than others to make.

_____ I understand that if, for any reason, I need to pick up my compound sooner than 5 days after requesting it, there is a **RUSH** option for a **$25 fee** to have it put in front of other compounds already in the lab. This will ensure it is the next compound in line.

_____ I understand that the pharmacist may not be available and will need to call me back after pulling my chart when I call with questions about symptoms/medications.

_____ I understand that a symptom update form will be requested each time I wish to have a change made to my compound.

_____ I understand that if I need to speak with the pharmacist for more than 5 to 10 minutes, I will need to schedule a one-on-one consultation and that there is a fee of $50 per 30 minutes for this service.

_____ I understand that The Medicine Shoppe will call me when my compound is ready to pick up (if I request it to be mailed, then they will mail it without calling). If I have not received a call in 5 days, I should call and check on the status.

**X** _____ **Date**_____

**Patient Signature**