We need:

☐ Any lab work within the last 6 months

☐ Copy of Driver's License

TLC MEDICAL CENTRE, INC.
Pharmacy • Medical Equipment

190 Crepe Myrtle Drive
Aiken, South Carolina 29803
Phone: 803.648.7800 • Fax: 803.648.7277

MEDICAL HISTORY/PATIENT SURVEY FORM
– FOR WOMEN –

Name: _____ **Date:** _____
How did you find out about us? _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
DOB: _____ **Age:** _____ **Phone:** _____
Email: _____ **Gender:** ☐ **M** ☐ **F**
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: _____
Doctor's Address: _____
Doctor's 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 occured?

_____
_____
_____

Over-the-counter (OTC) issues:
Please check all products you use occasionally or regularly. Check all that apply.

☐ Pain Reliever
☐ Aspirin
☐ Acetaminophen (ex: Tylenol)
☐ Ibuprofen (ex: Motrin IB)
☐ Naproxen (ex: Aleve)
☐ Ketoprofen (ex: Orudis KT)
☐ Cough Suppressant (ex: Robitussin DM)
☐ Antihistamine (ex: Chlor-Trimeton)
☐ Decongestant (ex: Sudafed)
☐ Combination product (cough+cold reliever, ex: TriaminicDM)
☐ Sleep Aids (ex: Unisom, Nytol, Sominex)
☐ Antidiarrheals (ex: Imodium, Pepto Bismol, Kaopectate)
☐ Laxatives/Stool Softener (ex: Doxidan, Correctol)
☐ Diet Aids/Weight Loss products (ex: Dexaril)
☐ Antacids (ex: Maalox, Mylanta)
☐ Acid Blockers (ex: Tagament HB, Pepcid C, Zantac 75)
☐ Other (please list)

Nutritional/Natural Supplements: Please identify and list the products you are using.

- ☐ Vitamins (ex: multiple or single vitamins such as B complex, E, C, beta carotene)
- ☐ Minerals (ex: calcium, magnesium, chromium, colloidal minerals, various single minerals
- ☐ Herbs (ex: Ginseng, Ginko, Biloba, Echinacea, other herbal medicinal teas, tinctures, remedies, etc.)
- ☐ Enzymes (ex: digestive formulas, papaya, bromelain, CoEnzyme Q10, etc.)
- ☐ Nutrition/Protein supplements (ex: shark cartilage, protein powders, amino acids, fish oils, etc.)
- ☐ Others (glucosamine, etc.)

Medical Conditions/Diseases: Please check all that apply to you.

- ☐ Heart Disease (ex: Congestive Heart Failure)
- ☐ High Cholesterol or Lipids (ex: Hyperlipidemia)
- ☐ High Blood Pressure (ex: Hypertension)
- ☐ Cancer
- ☐ Ulcers (stomach, esophagus)
- ☐ Thyroid Disease
- ☐ Hormonal Related Issues
- ☐ Lung Condition (ex: asthma, emphysema, COPD)
- ☐ Blood Clotting Problem
- ☐ Diabetes
- ☐ Arthritis or Joint Problems
- ☐ Depression
- ☐ Epilepsy
- ☐ Headaches/Migraines
- ☐ Eye Disease (glaucoma, etc.)
- ☐ Other: _____

_____

_____

Current Prescription Medications:

Medication Name	Strength	Date Started	How often per day

List Hormones Previously taken:

Date Started Date Stopped Reason

_____

_____

_____

_____

How long have you been on commercially available hormones? (ex: Premarin, Estratest, Birth Controls)

_____

Bone Size: ☐ Small ☐ Medium ☐ Large

Body Type: ☐ Androgenic (Muscular) ☐ Estrogenic (Curvy)

Have you ever used oral contraceptives? ☐ No ☐ Yes
Any problems? ☐ No ☐ Yes
If YES, describe any problem(s):

_____

_____

How many pregnancies have you had? _____ How many children? _____
Any interrupted pregnancies? ☐ No ☐ Yes
Have you had a hysterectomy? ☐ No ☐ Yes Date: _____
Ovaries removed? ☐ No ☐ Yes
Have you had a tubal Ligation? ☐ No ☐ Yes Date: _____

Do you have a family history of any of the following?

☐ Uteran 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? 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 occured, symptoms, etc.)

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 ☐ 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.

HORMONE REPLACEMENT THERAPY CONTINUED:

Trouble falling asleep or staying asleep, or both? How often do you wake up?

_____

_____

	ABSENT	MILD	MODERATE	SEVERE
Cramps	☐	☐	☐	☐
Fluid Retention	☐	☐	☐	☐
Breakthrough Bleeding	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐

All day, Sometimes, Afternoon, Just at night?

_____

_____

Decreased Stamina	☐	☐	☐	☐
Loss of Memory	☐	☐	☐	☐
Foggy Thinking	☐	☐	☐	☐
Bladder Symptoms	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐
Allergies	☐	☐	☐	☐
Harder to reach Climax	☐	☐	☐	☐
Decreased Sex Drive	☐	☐	☐	☐
Hair Loss	☐	☐	☐	☐
Incontinence	☐	☐	☐	☐
Uterine Fibroids	☐	☐	☐	☐
Ringing in Ears	☐	☐	☐	☐

HORMONE REPLACEMENT THERAPY PATIENT INFORMATION SHEET

Women:

	ABSENT	MILD	MODERATE	SEVERE
Fibrocystic Breast	☐	☐	☐	☐
Weight Gain	☐	☐	☐	☐
Heavy/Irregular Menses	☐	☐	☐	☐
Hot Flashes - *How many a day?* _____	☐	☐	☐	☐
Dry Skin/Hair	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Tearful	☐	☐	☐	☐
Mood Swings	☐	☐	☐	☐
Stress	☐	☐	☐	☐
Night Sweats - *How many a night?* _____	☐	☐	☐	☐
Vaginal Dryness	☐	☐	☐	☐
Headaches	☐	☐	☐	☐
Irritability	☐	☐	☐	☐
Anxious	☐	☐	☐	☐
Nervous	☐	☐	☐	☐
Breast Tenderness	☐	☐	☐	☐
Sleep Disturbances/Insomnia	☐	☐	☐	☐

Would you like to receive text notifications? ☐ No ☐ Yes

If yes, please provide phone number: _____

CURRENT MEDICAL STATUS

Describe your health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Height _____ Current Weight _____ Ideal Weight _____

Current diagnosis or medical conditions – *Check all that apply*

☐ Endometriosis	☐ PCOS	☐ Uterine Fibroids
☐ High blood pressure	☐ PMS	☐ Dysmenorrhea
☐ Fibrocystic Breast Disease	☐ Infertility	☐ Cancer
☐ Other _____		

Recent Mammogram? ☐ Yes ☐ No Date_____ Results _____

Recent Cholesterol screen? ☐ Yes ☐ No Date_____ Results _____

Recent Bone density scan? ☐ Yes ☐ No Date_____ Results _____

Recent Colonoscopy? ☐ Yes ☐ No Date_____ Results _____

Recent Blood Pressure? ☐ Yes ☐ No Date_____ Results _____

PAST MEDICAL CONDITIONS

Childhood diseases: _____

Check all boxes that apply

☐ heart disease	☐ IBS	☐ colitis	☐ gallbladder
☐ varicose veins	☐ high blood pressure	☐ thyroid	☐ fibromyalgia
☐ kidney trouble	☐ clotting defects	☐ elevated cholesterol	☐ anemia
☐ arthritis	☐ epilepsy	☐ stroke	☐ cancer
☐ asthma	☐ chronic fatigue syndrome	☐ diabetes	
☐ eating disorder		☐ fractures	

HABITS

Please List a brief example of a typical day's diet

Breakfast	
Snack	
Lunch	
Snack	
Dinner	
Snack	

Dietary Restrictions _____

Do you get routine physical exercise? ☐ Yes ☐ No Type/Frequency _____

How much water do you drink daily? _____

Your stresses (family, work, yourself, etc) _____

_____

_____

SYMPTOMS – Rate each symptom by checking the appropriate modifier.

	Absent	Mild	Moderate	Severe
Energy crashes mid-afternoon	☐	☐	☐	☐
Fatigue, lack of energy	☐	☐	☐	☐
Craving salty food	☐	☐	☐	☐
Exhausted easily	☐	☐	☐	☐
Sensitive to changes in weather	☐	☐	☐	☐
Loss of sex drive	☐	☐	☐	☐
Dark circles under eyes	☐	☐	☐	☐
Wounds heal slowly	☐	☐	☐	☐
Body tender/sensitive to touch	☐	☐	☐	☐
Feel puffy/swollen all over	☐	☐	☐	☐
Does your mind race at bedtime	☐	☐	☐	☐

Check the box if the statement applies to you.

- ☐ Have unusual fatigue unrelated to exertions?
- ☐ Feel chillier than others, often needing to wear socks to bed?
- ☐ Dress in layers because of needing to adjust to various temperatures?
- ☐ Have feelings of anxiety that sometimes lead to panic?
- ☐ Have trouble with weight, often eating lightly, still not losing a pound?
- ☐ Experience aches/pains in muscles/joints unrelated to trauma or exercise?
- ☐ Have increased problems with digestion or allergies?
- ☐ Feel mentally sluggish, unfocused, or unusually forgetful?
- ☐ Know of anyone in your family who has ever had a thyroid problem?
- ☐ Suffer from dry skin, or are prone to adult acne or eczema?
- ☐ Go through periods of depression, and/or lowered sex drive?
- ☐ Family history of diabetes, anemia, rheumatoid arthritis, or early graying hair?
- ☐ Experience your hair as feeling like straw, dry and easily falling out?
- ☐ Have history of whiplash or other neck injuries?
- ☐ Have a history of significant exposure to chlorine, bromine, or fluoride?
- ☐ Feel utterly exhausted by evening, yet have trouble sleeping?
- ☐ Do you wake up tired?
- ☐ First morning temperature (before your feet hit the floor)?_____

Cancer Waiver for Hormone Replacement Therapy

I, _____ voluntarily choose to participate in bio-identical Estradiol & Testosterone therapy with Custom Prescription Compounders, LLC, even though I have a history of cancer. I understand that such therapy is controversial and that many doctors believe that Estradiol replacement in my case in contraindicated. I understand, acknowledge and am informed that it is possible that taking estrogen (Estradiol, Estriol or Estrone, progesterone, or growth hormone) could possibly cause cancer, or stimulate existing cancer (including one that has not yet been detected).

Accordingly, I have assessed this risk on a personal basis, and my perceived value of the hormone therapy outweighs the risk in my mind. I am, therefore, choosing to ask for and participate in this therapy despite the potential risk.

I acknowledge that i bear full responsibility for any personal injury or illness, accident, risk or loss that may be sustained by me in connection with my decision to undergo Estradiol therapy including, without limitation, any cancer that should develop in the future, whether it be deemed to result from a stimulation of a current cancer or a new cancer. I hereby release and agree to hold harmless Custom Prescription Compounders, LLC, all pharmacists, staff, technicians, employees and agents from any and all liability, claims, demands and actions arising or related to any loss, property damage, illness, injury or accident that may be sustained by me as a result of my decision to undergo Estradiol therapy including, without limitation, any cancer that should develop in the future, whether it be deemed a stimulation of a current cancer or new cancer.

I acknowledge and agree that I have been given adequate opportunity to review this document and to ask questions. This release and hold harmless agreement is and shall be binding on myself and my heirs, assigns and personal representatives.

Patient Signature: _____ Date: ___/___/_____

Medical Release

I, _____ allow the release of any and all information necessary to help in managing my hormone replacement therapy, blood nutrition and/or any other medical information directly or indirectly related to my health care to Custom Prescription Compounder, LLC/TLC Medical Centre Inc. (Lab work, past and present medications, and any other pertinent information.

Patient Signature: _____ Date: ___/___/_____

Smoking Waiver

I acknowledge the fact that if I continue to smoke cigarettes, vaping or use any nicotine product, or be exposed to secondary smoke while participating in hormone replacement therapy, I fully understand the consequences of my actions.

Nicotine greatly increases my health risks for complications including, but not limited to, wound healing problems, scarring, fluid accumulations, and even life threatening complications like leg vein clotting which can dislodge and go to the lungs and be fatal.

Any and all of these complications can lead to a poor result for my hormone replacement therapy beyond the control of Custom Prescription Compounders, LLC and its staff. I have been told that smoking, all tobacco use and vaping should be stopped.

Patient Signature: _____ Date: ___/___/_____

or

This WAIVER does not apply to me _____

Pregnancy Waiver

I, _____ understand that Bio-Identical Hormones (BHRT) will not help me become pregnant nor keep me from becoming pregnant. If I do become pregnant, I understand that Custom Prescription Compounders, LLC is not responsible. I will let Custom Prescription Compounders, LLC know when I become pregnant so I can be released from my hormone therapy.

Patient Signature: _____ Date: ___/___/_____

Ways to return completed forms:
- zoomrx@bellsouth.net
- Fax 803-648-7277
- Zoom Heaton
  P.O. Box 6296
  Aiken, SC 29804-6296