BETTER Rx LIVING
Compounding Pharmacy
and Wellness Center

1039 N Twin City Hwy Nederland, TX 77627
Phone 409-727-8660 Fax 409-727-8670

Medical History & Evaluation

Today's Date:_____

Name: _____ **Birthday:**_____ **Age:**_____

Address: _____ **City:** _____**State:** _____ **Zip:** _____

Phone: _____ **Cell Phone:** _____

Email 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(pollen)
_____ 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.

___ 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)
___ Decongestant product (example: Sudafed®)
___Combination product (cough+cold reliever)(example: TriaminicDM®)
___ Sleep aids (examples: Excedrin PC®, Unisom®, Sominex®, Nytol®)
___ Antidiarrheals (examples: Imodium®, Pepto Bismol®, Kaopectate®)
___ Laxatives/stool softeners (example: Doxidan®, Correctol®, etc.)
___ Diet aids/weight loss products (example: Dexatril®)
___ Antacids (examples: Maalox®, Mylanta®)
___ Acid blockers (example: Tagamet HB®, Pepcid C®, Zantac 75®)
___ Other (please list)
_____

PATIENT NAME: _____

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

□ 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 □ Estrogenic

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

_____

_____

PATIENT NAME: _____

Have you had any of the following tests performed? Check those that apply and not 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:

_____

_____

_____

PATIENT NAME: _____

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.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PATIENT NAME: _____

Gynecological History

Have you ever had an abnormal Pap? _____ Treatment: _____

Age at first period: _____ Date of last period: _____

Date of last pelvic exam: _____ and Pap smear: _____ Results:_____

Are you sexually active? _____ Are you trying to get pregnant? _____

Current birth control method: _____ How long? _____

Past birth control and any related problems: _____

How many days from the start of one period to the start of the next? _____

Number of days of flow: _____ Amount of bleeding: _____

Amount of cramps: _____

Premenstrual Symptoms: _____

Starting and ending when? _____

Any current changes in your normal cycle? _____

Any bleeding between periods? _____ When? _____

Any pelvic pain, pressure, or fullness? _____ Describe: _____

Any unusual vaginal discharge or itching? _____ Describe: _____

Treatment: _____

Age at first pregnancy: _____

How many full-term pregnancies? _____ Problems: _____

_____

Any interrupted pregnancies (miscarriages or abortions)? _____ Problems: _____

_____

Have you had a tubal ligation? _____ When? _____

Have you had any part or whole ovary removed? _____ When? _____

Have you had a hysterectomy? _____ When? _____

Do your ovaries remain? _____

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

Uterine 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)_____