Please return Hormone evaluation to Homer Drugs in person, by fax or email.
Fax: 706-677-3602 Email: kim@homerdrug.com

Today's Date:_____ Name:_____ Birthdate:_____ Age:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Day Phone:_____ Night Phone:_____ Height:_____

Email:_____ Gender ☐Male ☐Female Weight:_____

Do you use tobacco? ☐Yes ☐No How much & How often?_____
Do you use alcohol? ☐Yes ☐No How much & How often?_____
Do you use caffeine? ☐Yes ☐No How much & How often?_____

Doctor's Name:_____ Doctor's Phone:_____

Allergies:_____

Please describe the allergic reaction you experienced and when it occurred?_____
_____

OTC (over-the-counter) Medications. Please check all products that you use occasionally or regularly.

☐Pain Reliever
☐Aspirin
☐Acetaminophen (example: Tylenol)
☐Ibuprofen (example: Motrin)
☐Naproxen (example: Aleve)
☐Ketoprofen (example: Orudis KT)
☐Cough Suppressant (example: Robitussin DM)
☐Antihistamine product (example: Benadryl)
☐Decongestant (example: Sudafed)
☐Combination product (cough&cold reliever, example: Robitussin CF)
☐Sleep Aids (examples: Unisom, Sominex, Tylenol PM)
☐Antidiarrheals (examples: Imodium, Pepto Bismol, Kaopectate)
☐Laxatives/stool softeners (examples: Doxidan, Correctol, Dulcolax)
☐Diet aids/Weight loss products
☐Antacids (examples: Maalox, Mylanta)
☐Acid Blockers (examples: Tagamet, Pepcid, Zantac, Prilosec)
☐Other: Please list:_____
_____

Nutritional/Natural Supplements: Please check all products that you use occasionally or regularly.

☐Vitamins (examples: multiple or single vitamins such as b complex, E, C, beta carotene, etc.)
☐Minerals (examples: calcium, magnesium, chromium, etc.)
☐Herbs (examples: Ginseng, Ginkgo Biloba, Echinacea, etc.)
☐Enzymes (examples: Digestive formulas, papaya, bromelain, CoEnzyme Q10, etc.)
☐Nutrition/Protein supplements (examples: shark cartilage, protein powders, amino acids, fish oils, etc.)
☐Others (glucosamine, etc.) Please list:_____

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

☐Heart Disease
☐High Cholesterol or lipids
☐Cancer
☐Ulcers (stomach, esophagus)
☐Thyroid disease
☐Blood Clotting Problems
☐Diabetes
☐Arthritis or joint problems
☐Depression
☐Epilepsy

☐Hormonal Related issues ☐Headaches/Migraines
☐Lung condition (asthma, COPD, emphysema) ☐Eye Disease (glaucoma, etc)
☐Other:_____

If Breast Cancer, was it Hormone Positive? ☐Yes ☐No

If Thyroid Disease, please obtain a copy of your last thyroid profile.

Current Prescription Medications:

Medication Name	Strength	Date Started	Directions

List Hormones previously taken: Date Started Date Stopped Reason

_____

_____

_____

Bone Size: ☐Small ☐Medium ☐Large

Body Type: ☐Estrogenic (pear) ☐Androgenic (apple)

Have you ever used oral contraceptives? ☐Yes ☐No
Any problems:

_____

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

Have you had a hysterectomy? ☐Yes ☐No Date of Surgery:_____
Ovaries Removed? ☐Yes ☐No

Have you had a tubal ligation? ☐Yes ☐No Date of Surgery:_____

Do you routinely exercise? ☐Yes ☐No If Yes, what type and how often?_____

_____

Does your diet include the following?
☐Fresh Fruits ☐Frequent fast foods or high fat foods
☐Fresh Vegetables ☐Processed Foods
☐Whole Grains

Do you suffer from insomnia? ☐Yes ☐No

Please rate your stress level: ☐High ☐Moderate ☐Low

Check any of the following that apply:

☐Family history of osteoporosis
☐Sedentary lifestyle
☐Smoker
☐Steroid Use (Prednisone)
☐Frequent missed periods (before menopause)
☐Decreased exposure to sunlight
☐Drink several carbonated drinks per day
☐Drink several caffeinated drinks per day
☐Low Body weight

Check any of the following that apply:

☐Began menses before 12 years old
☐Menopause after age 55
☐First live birth after age of 30
☐Family history of Breast Cancer
☐Previous breast lump biopsy
☐Previous Estrogen Replacement Therapy

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

☐Uterine Cancer Family Member:_____
☐Ovarian Cancer Family Member:_____
☐Fibrocystic Breasts Family Member:_____
☐Heart Disease Family Member:_____
☐Breast Cancer Family Member:_____
☐Osteoporosis Family Member:_____

Have you had any of the following tests performed? Check those that apply and note date of last test:

Mammography ☐Yes ☐No Date:_____
Pap Smear ☐Yes ☐No Date:_____

Since you first began having periods, have you ever had what YOU would consider to be abnormal cycles?
☐Yes ☐No
If Yes, Please explain:_____

_____

_____

When was your last period?_____

How many days did it last?_____

Do you or have you ever had PMS? ☐Yes ☐No
If yes, explain symptoms:_____

_____
What are your goals in taking BHRT?

_____

_____

Hormone Replacement Therapy Patient Symptom Sheet

	Absent	Mild	Moderate	Severe
Fibrocystic Breast	_____	_____	_____	_____
Weight Gain	_____	_____	_____	_____
Heavy/Irregular Menses	_____	_____	_____	_____
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 reach Climax	_____	_____	_____	_____
Decreased Sex Drive	_____	_____	_____	_____
Hair Loss	_____	_____	_____	_____