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
☐Hormonal Related issues
☐Lung condition (asthma, COPD, emphysema)
☐Blood Clotting Problems
☐Diabetes
☐Arthritis or joint problems
☐Depression
☐Epilepsy
☐Headaches/Migraines
☐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
☐ Fresh Vegetables
☐ Whole Grains
☐ Frequent fast foods or high fat foods
☐ Processed Foods

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	______	______	______	______