Lakeland Pharmacy

Hormone Evaluation

Medical History

GENERAL INFORMATION

Name: ____ Birthdate: __________________ Age: _________

Address: ____Phone: ____________________________________

City: _______________________________________ State: _____________________ Zip: ________________

Email: ____ Height: _________________ Weight: _________

Do you use tobacco? ______________ How often/how much? ___________/_____________

Do you use alcohol: __________ How often/how much? ___________/_____________

Do you use caffeine? __________ How often/how much? ___________/_____________

Doctor's Name	**Address**	**Phone**
_________________________	__________________________________	____________________
_________________________	__________________________________	____________________
_________________________	__________________________________	____________________

ALLERGIES

____ Penicillin ____ Morphine ____ Dye Allergies ____ Pet Allergies ____ Codeine

____ Seasonal Allergies ____ Sulfa Drug ____ Food Allergy ____ Aspirin ____ Nitrate Allergy

____ No Known Allergies ____ Other:_________________________________

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

____

Are you allergic to milk or milk products? _____ Yes _____ No

CURRENT MEDICATIONS

Over the counter issues: ____

___ Pain reliever

___ Aspirin

___ Acetaminophen (Tylenol)

___ Ibuprofen (Motrin)

___ Ketoprofen (example: Orudis KT)

___ Cough Suppressant (Robitussin DM)

___ Antihistamine Product

____ Combination Product (cough + cold reliever) (example: Triaminic DM)

____ Sleep Aids (example: Excedrin PC, Unisom, Sominax, Nitol)

____ Antidiarrheal (examples: Imodium, Pepto Bismol)

____ Laxatives/stool softener

____ Diet Aids/Weight loss products

____ Antacids

____ Decongestant

____ Acid Blockers (Tagamet HB, Pepcid AC)

____ Others (please list): ________________

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PATIENT NAME: ____ **Date:** _________________________________

NUTRITIONAL /NATURAL SUPPLEMENTS: (Please identify and list the products you are using)

___ Vitamins (example:: Multiple or single vitamins such as B complex, E, C, Beta Carotene)
___ Minerals (example: Calcium, Magnesium, Chromium, Colloidal Minerals)
___ Herbs (example: Ginseng, Gingko Biloba, Echinacea, Other Herbal Teas, Remedies, etc.)
___ Enzymes (example: Digestive formulas papaya, Co Enzyme Q10, etc.)
___ Nutritional/Protein Supplements (example: Shark Cartilage, Protein powders, Amino Acids)
___ Other (Glucosamine, etc.) ____

CURRENT PRESCRIPTION MEDICATIONS

Medication Name	Strength	Date Started	How Often
___________________________	_______________	_________________	________________
___________________________	_______________	_________________	________________
___________________________	_______________	_________________	________________
___________________________	_______________	_________________	________________

PERSONAL MEDICAL HISTORY

Medical conditions/Diseases: (Please check all that apply)

___ Heart Disease	___ Blood Clotting Problems	___ Epilepsy
___ High Cholesterol	___ Diabetes	___ Headaches
___ High Blood Pressure	___ Arthritis	___ Migraines
___ Cancer	___ Depression	___ Eye Disease
___ Fibromyalgia	___ Thyroid Disease	___ Ulcers

___ Other (please list): ____

PERSONAL HORMONE INFORMATION

Hormones previously taken	Date started	Date stopped	Reason
________________________________	________________	_________________	______________
________________________________	________________	_________________	______________
________________________________	________________	_________________	______________

Have you ever used oral contraceptives? __ Yes __ No
Any problems? Describe: ____
How many pregnancies have you had? ______ How many children? ______
Any interrupted pregnancies? ___ Yes ___ No
Have you had a hysterectomy? ___ Yes ___ No Date of surgery: ________________
Ovaries removed? ___ Yes ___ No
Have you had a tubal ligation? ___ Yes ___ No Date: ________________________
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: ________________________

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PATIENT NAME: ____ **Date:** _________________________

Since you first began having periods, have you ever had what YOU consider to be abnormal cycles?

___ Yes ___ No Date: _______________________

If YES, please explain (such as age when this occurred, symptoms, etc.): __________________________________

____

____

When was your last period? ____

How many days did it last? ____

Do you have, or did you have Premenstrual Syndrome (PMS)? ___ Yes ___ No

If YES, explain symptoms: ____

Would you prefer to take your Bio-Identical Hormone Replacement Therapy in the form of a cream or capsule? ______

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 Bio-Identical Hormone Replacement Therapy?

____

____

____

Please write down any questions you have about Bio-Identical Hormone Replacement Therapy.

____

____

____

FAMILY HISTORY

Dou have a family history of any of the following?

Uterine Cancer _______________________ Family Member (s) ______________________________

Ovarian Cancer _______________________ Family Member (s) ______________________________

Fiber cystic Breast _______________________ Family Member (s) ______________________________

Breast Cancer _______________________ Family Member (s) ______________________________

Heart Disease _______________________ Family Member (s) ______________________________

Osteoporosis _______________________ Family Member (s) ______________________________

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