Barney's Pharmacy
2604 Peach Orchard Road
Augusta GA 30909
Phone: (706) 849-3450
Fax: (706) 993-4143

Bioidentical Hormone Replacement Therapy

CONFIDENTIAL EVALUATION

From a clinical management point of view, it is very useful to gain a detailed history of possible hormone deficiencies. The answers provided in the questions below will allow the pharmacist to maintain your medical history and will help in advising about current medicinal therapies. All information provided will be kept confidential.

GENERAL INFORMATION **DATE.**_________________________

Name: ____ Birth Date:_____________________

Address: ____

Home Phone: _______________________________ Work/Cell Phone: ________________________________

Occupation: ______________________________________ Full Time____ Part Time ____ Retired ____

Status: Married _____ Single: _____ Divorced: _____ Widowed: _____

How did you hear about Bioidentical Hormone Replacement Therapy? Ad _____ Another Patient _____

Book _____ Course/Seminar _____

Physician _____ Other: ____________

What are your goals of BHRT? ____

____

____

MEDICAL STATUS

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Age ____________ Height _____________ Weight ______________

General Health: Excellent _______ Good ______ Fair _______ Poor ________

Current medical conditions: ____

____

____

Drug Allergies: ____

Allergies to food, pollens, etc.: ____

Current Medications: ____

____

____

____

Current Scheduled or As Needed Over-the-Counter Products: ____

____

Current Vitamins or Mineral/Herbal Supplements: ____

____

Have you ever had a mammogram? YES NO Date:__________ Results: _____________________

Have you ever had a bone density scan? YES NO Date: __________ Results: _____________________

Current Health Care Providers:

____

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PAST MEDICAL CONDITIONS

Heart Trouble _____ High Blood Pressure _____ Stroke _____ Varicose Veins _____ Diabetes _____

Clotting Defects _____ Kidney Trouble _____ Epilepsy _____ Fractures _____ Arthritis _____

Colitis _____ Gallbladder Trouble _____ Asthma _____ Cancer _____ (What type?) _______________

Fibromyalgia _____ Eating Disorder _____ Chronic Fatigue _____ Other: ________________________

DIETARY

List Any Dietary Restrictions:____

Do you get routine physical exercise? YES NO Type of Exercise Preferred?
____

Do you use tobacco products? YES NO How much? _______________ For how long? _____________

Do you consume alcohol products? YES NO How much? _______________ How often? ___________

Do you consume caffeine products? YES NO How much? ______________ How often? ___________

FAMILY HISTORY

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Please list family members and their age which are *still living* that may have important diseases such as: High Blood Pressure, Heart Disease, Cancer, Diabetes, Osteoporosis, etc:

____

____

____

____

Please list any family members who died of important diseases (see above question) and their age at the time of death: ____

____

____

GYNECOLOGICAL HISTORY

Age at first period:_________________________ Date of last period:____________________________

Date of last pelvic exam: __________ Date of last pap smear: _________ Results:____________________

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Have you ever had an abnormal pap? YES NO Treatment:____

Are you sexually active? YES NO Are you trying to get pregnant? YES NO

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

Number of days of flow: _________________ Amount of bleeding:_________________________________

Do you experience cramping? YES NO Premenstrual symptoms: __________________________________

Any bleeding between periods? _________

When:____

Any pelvic pain, pressure, or fullness? YES NO Describe:____

Any unusual vaginal discharge or itching? YES NO Describe: _______________________________________

Age at 1st pregnancy: _______ How many full- term pregnancies: ______ Problems: ______________________

Any interrupted pregnancies? (Miscarriages or abortions) YES NO

Have you had a tubal ligation? YES NO When: ____

Have you had a hysterectomy? YES NO When:_____________ Remove ovaries? YES NO

PAST/ CURRENT HORMONE REPLACEMENT THERAPY

Please list any Hormone Replacement you have taken: (Birth Control, Estrogens. Progestins, etc.)

Medication	Dates Taken	Problems? Reasons for stopping

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SYMPTOMS: Please rate your current status for each symptom

	ABSENT	MILD	MODERATE	SEVERE	Notes
Hot Flashes					
Night Sweats					
Headaches					

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Insomnia					
Breast Tenderness					
Irritability					
Depression					
Weight Gain					
Low Libido					
Fuzzy Thinking					
Bloating					
Anxiety					
Mood Swings					
Vaginal Dryness					
Fatigue					
Hair Loss					