Shinabery's
Compounding Pharmacy

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Confidential Hormone Evaluation

Today's Date:_____

Name: _____ **Birthdate:** _____ **Age:** _____

Address: _____

City: _____ **State:** ____ **Zip code:** _____ **Cell:** _____

Home Phone: _____ **Work Phone:** _____ **E-mail:**_____

Gender: Male ____ Female ____ **Height:** _____ **Weight:** _____

			How much and how often?
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
___ codeine	___ aspirin	___ nitrate	___ seasonal
___ sulfa drug	___ food	___ No known allergies	others_____

Please describe the allergic reaction you experienced?

_____
_____
_____

Patient Name:_____

Over-the-Counter (OTC) products: Please list products you take occasionally or regularly.

_____

_____

_____

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

_____

_____

_____

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

___ Heart Disease (example: Congestive Heart Failure)
___ High cholesterol or lipids
___ High blood pressure
___ Cancer
___ Ulcers
___ Thyroid disease
___ Hormonal Related Issues
___ Lung conditions
___ Blood Clotting Problems
___ Diabetes
___ Arthritis or joint problems
___ Depression
___ Epilepsy
___ Headaches/migraines
___ Eye Disease
___ Other:_____

_____

_____

List Hormone Medications Presently taking:

Medication Name:	Strength:	Date Started:	How often per day:

Current Prescription Medications: If more room is needed attach a separate sheet.

Medication Name:	Strength:	Date Started:	How often per day

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

Patient Name: _____

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

Any interrupted pregnancies? No ___ Yes ___
Have you had a hysterectomy? No ___ Yes ___ (Date) _____
Ovaries removed? No ___ Yes ___
Have you had a tubal ligation? No ___ Yes ___ (Date) _____

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) _____

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

Mammography No ___ Yes ___ Date: _____
PAP Smear No ___ Yes ___ Date: _____

Since you first began having periods, have you every had what YOU would consider to be abnormal cycles? No ___ Yes ___

If yes, please explain (such as age when this occurred, symptoms...):

_____
_____
_____
_____

Are you still having a menstrual cycle? No ____ Yes ____

Date of last period? _____

How long does (or did) your cycle 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?

What are your goals with taking BHRT?

Please write down any questions you have about BHRT.

Patient Name: _____ **Date:** _____

HORMONE EVALUATION OF SYMPTOMS

	ABSENT		MILD			MODERATE			SEVERE		
Fibrocystic Breast	0	1	2	3	4	5	6	7	8	9	
Weight Gain	0	1	2	3	4	5	6	7	8	9	
Heavy/Irregular Menses	0	1	2	3	4	5	6	7	8	9	
Hot Flashes	0	1	2	3	4	5	6	7	8	9	
Dry Skin/Hair	0	1	2	3	4	5	6	7	8	9	
Anxiety	0	1	2	3	4	5	6	7	8	9	
Depression	0	1	2	3	4	5	6	7	8	9	
Night Sweats	0	1	2	3	4	5	6	7	8	9	
Vaginal Dryness	0	1	2	3	4	5	6	7	8	9	
Headaches	0	1	2	3	4	5	6	7	8	9	
Irritability	0	1	2	3	4	5	6	7	8	9	
Mood Swings	0	1	2	3	4	5	6	7	8	9	
Breast Tenderness	0	1	2	3	4	5	6	7	8	9	
Trouble going to Sleep	0	1	2	3	4	5	6	7	8	9	
Trouble staying Sleep	0	1	2	3	4	5	6	7	8	9	
Cramps	0	1	2	3	4	5	6	7	8	9	
Fluid Retention	0	1	2	3	4	5	6	7	8	9	
Breakthrough Bleeding	0	1	2	3	4	5	6	7	8	9	
Fatigue	0	1	2	3	4	5	6	7	8	9	
Loss of Memory	0	1	2	3	4	5	6	7	8	9	
Bladder Symptoms	0	1	2	3	4	5	6	7	8	9	
Arthritis	0	1	2	3	4	5	6	7	8	9	
Harder to Reach Climax	0	1	2	3	4	5	6	7	8	9	
Decreased Sex Drive	0	1	2	3	4	5	6	7	8	9	
Hair Loss	0	1	2	3	4	5	6	7	8	9	