

Magnolia Pharmacy

CONFIDENTIAL HORMONE EVALUATION - FEMALE

Today's Date: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ E-Mail Address: _____
(Please indicate with an * which way you would like us to contact you)

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

Allergies: Please check all that apply

penicillin morphine dye allergies pet allergies
 codeine aspirin nitrate allergy seasonal allergies
 sulfa drug food allergies no known allergies

Other: _____

Please describe the allergic reaction: _____

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

heart disease (example: congestive heart failure) blood clotting problems
 high cholesterol high triglycerides diabetes
 high blood pressure arthritis cancer (type: _____)
 depression headaches/migraines epilepsy
 ulcers chronic pain GERD
 hypothyroidism hyperthyroidism asthma
 emphysema COPD glaucoma
 psoriasis interstitial cystitis fibromyalgia
 irritable bowel syndrome (IBS/IBD)
 other: _____

PATIENT NAME: _____

Current Medications: Please list all medications you are currently taking. Include prescription medications, over the counter medications, and supplements/herbs.

Name of Medication	Dose	How often per day	Date Started

List Hormones previously taken:	Date Started	Date Stopped	Reason

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

Height: _____ Weight: _____ BMI (pharmacist will calculate): _____
Bone Size _____ small _____ medium _____ large

Body Type: _____ apple _____ pear

Any recent dramatic weight changes? _____ No _____ Yes
If Yes, describe:
How much? _____ Gain or Loss? _____
Over what time period? _____

How frequent are your bowel movements? _____

Your weight at birth? _____

PATIENT NAME: _____

How many pregnancies have you had? _____ How many children? _____
Did you breastfeed your children? _____ No _____ Yes
Any miscarriages? _____ No _____ Yes
Have you had a hysterectomy? _____ No _____ Yes (Date of Surgery) _____
Ovaries removed? _____ No _____ Yes
Please list any other recent surgeries (including gastric bypass)

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) _____
Colon Cancer _____	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: _____

Age when your menstrual period began: _____ Since that time have you ever had what YOU would consider to be abnormal cycles? _____ No _____ Yes
If Yes, please explain: _____

When was your last period? _____ How long did it last? _____

Do you have, or did you ever have Premenstrual Syndrome (PMS)? _____ No _____ Yes
If Yes, please explain symptoms: _____

PATIENT NAME: _____

Do you smoke? NO _____ YES _____ – how much and for how long _____

How many caffeinated beverages do you drink per day? _____
Portion size _____

How much water do you drink per day? _____ Portion size _____

How many alcoholic beverages do you consume in an average week? _____

How many meals a day do you eat? _____

Please describe your:

Typical breakfast: _____

Typical lunch: _____

Typical dinner: _____

Do you have trouble waking up in the mornings? _____ No _____ Yes

Do you take naps during the day? _____ No _____ Yes

Do you have trouble falling asleep at night? _____ No _____ Yes

Do you have trouble staying asleep? _____ No _____ Yes

Comments about sleep patterns: _____

Do you work outside the home? _____ No _____ Yes

How many hours per week? _____

Do you enjoy your job? _____

Do you find your job stressful? _____

Do you find your job satisfying? _____

Do you take care of small children, elderly, or disabled adults? _____ No _____ Yes

If Yes, explain: _____

Do you have a hobby? _____ No _____ Yes

What activity relaxes you? _____

How often are you able to do this activity? _____

Is there a place in your home that you can go to relax and be alone? _____ No _____ Yes

Do you belong to a social or activity group outside of your family? _____ No _____ Yes

Do you have a current exercise routine? _____ No _____ Yes

If Yes, what kind of exercise and how often per week: _____

Comments: _____

PATIENT NAME: _____

Please rate the following symptoms in severity from 0 to 3, 0 being absent and 3 being severe.

Hot Flashes	_____	Evening Fatigue	_____
Night Sweats	_____	Arthritis	_____
Vaginal Dryness	_____	Bone Loss	_____
Bladder Symptoms	_____	Rapid Aging	_____
Fibrocystic Breast	_____	Harder to Reach Climax	_____
Heavy/Irregular menses	_____	Decreased Sex Drive	_____
Fluid Retention	_____	Painful Intercourse	_____
Anxiety	_____	Dry Skin	_____
Depression	_____	Dry/Brittle Hair	_____
Foggy Thinking	_____	Dry/Brittle Nails	_____
Loss of Memory	_____	Hair Loss	_____
Irritability	_____	Constipation	_____
Mood Swings	_____	Pelvic Pain	_____
Breast Tenderness	_____	Increase in Facial Hair	_____
Trouble Sleeping	_____	Weight Gain - Hips	_____
Sugar Craving	_____	Weight Gain – Waist	_____
Headaches	_____	Cramps	_____
Morning Fatigue	_____	Breakthrough Bleeding	_____

Symptom Numerical Total _____

PATIENT NAME: _____

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 BHRT?

Please write down any questions you have about BHRT or this form.

PATIENT NAME: _____

LIFE STRESS TEST

In a now-famous American study from 1967, Dr. Thomas H. Holmes and Dr. Richard H. Rahe created a do-it-yourself stress test. They examined the stress - measured the Life Changes (LCU) – that induced by experiences ranging from death of a spouse to getting a traffic ticket. By adding the LCU values of the past year, you can predict the likelihood of stress related illness or accident.

CHANCE OF ILLNESS OR ACCIDENT WITHIN 2 YEARS.

Total LCU below 150 – 35%
Total LCU between – 150 to 300 – 51%
Total LCU over 300 – 80%

_____ Death of Spouse - 100	_____ Change in work responsibilities – 29
_____ Divorce – 73	_____ Trouble with in-laws – 29
_____ Marital Separation – 65	_____ Outstanding personal achievement – 28
_____ Jail Term – 63	_____ Spouse begins or stops work – 26
_____ Death of close family member – 63	_____ Starting or finishing school – 26
_____ Personal injury or illness – 53	_____ Change in living conditions – 25
_____ Marriage – 50	_____ Revision of personal habits – 24
_____ Fired from work – 47	_____ Trouble with boss – 23
_____ Marital reconciliation – 45	_____ Change in work hours or conditions – 20
_____ Retirement – 45	_____ Change in residence – 20
_____ Change in family members health – 44	_____ Change in schools – 20
_____ Pregnancy – 40	_____ Change in recreational habits – 19
_____ Sex difficulties – 39	_____ Change in social activities – 18
_____ Addition to family – 39	_____ Mortgage or loan under \$10,000 – 17
_____ Business readjustment – 39	_____ Change in sleeping habits – 16
_____ Change in financial status – 38	_____ Change in number of family gatherings – 15
_____ Death of close friend – 37	_____ Change in eating habits – 15
_____ Change to different line of work – 36	_____ Vacation – 13
_____ Change in number of marital arguments – 35	_____ Christmas season – 12
_____ Mortgage or loan over \$10,000 – 31	_____ Minor violations of the law – 11
_____ Foreclosure of mortgage or loan – 30	_____ YOUR TOTAL

This scale shows the kind of life pressure that you are facing. Depending on your coping skills or the lack thereof, this scale may predict the likelihood that you will fall victim to a stress related illness. This illness could be frequent tension headaches, acid indigestion, loss of sleep, to very serious illness like ulcers, cancer and migraines.

Daily practice of relaxation skills is very important for your wellness.
Take care of it now before serious illness erupts or an affliction becomes worse.