

# 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: \_\_\_\_\_



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)

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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?

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

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PATIENT NAME: \_\_\_\_\_