



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? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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**MEDICAL STATUS**

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: \_\_\_\_\_



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Current Health Care Providers: \_\_\_\_\_

\_\_\_\_\_

### 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? \_\_\_\_\_



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## **FAMILY HISTORY**

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: \_\_\_\_\_

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

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## GYNECOLOGICAL HISTORY

Age at first period: \_\_\_\_\_ Date of last period: \_\_\_\_\_

Date of last pelvic exam: \_\_\_\_\_ Date of last pap smear: \_\_\_\_\_ Results: \_\_\_\_\_

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





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**SYMPTOMS:** Please rate your current status for each symptom

	<b>ABSENT</b>	<b>MILD</b>	<b>MODERATE</b>	<b>SEVERE</b>	<b>Notes</b>
Hot Flashes					
Night Sweats					
Headaches					
Insomnia					
Breast Tenderness					
Irritability					
Depression					
Weight Gain					
Low Libido					
Fuzzy Thinking					
Bloating					
Anxiety					
Mood Swings					
Vaginal Dryness					
Fatigue					
Hair Loss					