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Natural Hormone Replacement 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 medical therapies. All information provided will be kept confidential.

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GENERAL INFORMATION

Date: _____

Name: _____ Age: _____ Birth date: _____

Address: _____

Home phone: _____ Work phone: _____

Occupation: _____ Full-time Part-time Retired Unemployed Other

Living Situation: Spouse Alone Partner Friend(s) Parents Children Other

Status: Married Single Divorced Widowed

Pets: _____

How did you hear about Natural Hormone Replacement Therapy? Ad Another patient

Courses/Seminars Physician/Healthcare practitioner Books/Articles Other

Do you understand what Natural Hormone Replacement is? _____

What are your goals for Natural Hormone Replacement? _____

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MEDICAL STATUS

General Health: Excellent Good Fair Poor Height: _____ Weight: _____

Current diagnosis or medical conditions: _____

Drug allergies: _____

Allergies to food, pollen, etc: _____

Current Medications: _____

Current vitamins or OTC products: _____

Current Herbs/etc: _____

Have you ever had your cholesterol level checked? Yes No Date: _____ Results: _____

Have you ever had your Hemoglobin A1C checked Yes No Date: _____ Results: _____

Have you ever had a PSA test? Yes No Date: _____ Results: _____

Have you ever had a bone density scan? Yes No Date: _____ Results: _____

Current/Recent Health Care Providers: _____

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PAST MEDICAL CONDITIONS

Childhood diseases: _____

Heart Trouble High Blood Pressure Stroke Varicose Veins Clotting Defects

Diabetes Kidney Trouble Epilepsy Fractures Arthritis Colitis Cancer

Gallbladder Trouble Asthma Chronic Fatigue Fibromyalgia Eating Disorder

Psoriasis Eczema

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HABITS

Dietary Restrictions: _____

Meal Choices: Breakfast: _____

Lunch: _____

Dinner: _____

Do you get routine physical exercise? _____ What type? _____

Do you use tobacco products? _____ How much? _____ Previously: _____ How long: _____

Do you use alcohol products? _____ How much? _____ Previously: _____ How long: _____

Do you use caffeine products? _____ How much? _____

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FAMILY HISTORY

Please list family member and their ages who are still living that may have important disease such as: High Blood Pressure, Heart Disease, Cancer, Diabetes, Osteoporosis, etc: _____

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

SYMPTOMS I

Rate your current status for each symptom by checking the appropriate modifier. Please feel free to use additional space to describe any symptom. This section may be repeated upon subsequent visits.

	Absent	Mild	Moderate	Severe
1.	_____	_____	_____	_____
<hr/>				
2. Low Libido	_____	_____	_____	_____
<hr/>				
3.	_____	_____	_____	_____
<hr/>				
4.	_____	_____	_____	_____
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5.	_____	_____	_____	_____
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6.	_____	_____	_____	_____
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7.	_____	_____	_____	_____
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8.	_____	_____	_____	_____
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9.	_____	_____	_____	_____
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10.	_____	_____	_____	_____
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11.	_____	_____	_____	_____
<hr/>				
12.	_____	_____	_____	_____
<hr/>				
13.	_____	_____	_____	_____
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SYMPTOMS II

Rate your current status for each symptom by checking the appropriate modifier. Please feel free to use additional space to describe any symptom. This section may be repeated upon subsequent visits.

Absent **Mild** **Moderate** **Severe**

1. _____ _____ _____ _____

2. _____ _____ _____ _____

3. _____ _____ _____ _____

4. _____ _____ _____ _____

5. _____ _____ _____ _____

6. _____ _____ _____ _____

