



**Bio-Identical Hormone Replacement 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.*

**GENERAL INFORMATION**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt. \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Full-Time Part-Time Retired Unemployed Other

Telephone number: Day: \_\_\_\_\_ Evening: \_\_\_\_\_

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

Status: Married Single Divorced Widowed EMAIL ADDRESS \_\_\_\_\_

How did you hear about Natural Hormone Replacement Therapy?: Ad Another Patient Friend

Physician/Health Practitioner Books/Articles Class/Seminar Other

If you had a referral, who referred you?: \_\_\_\_\_

Have you discussed HRT with your Health Care Practitioner?: \_\_\_\_\_

Do you understand what Natural Hormone Replacement is?: \_\_\_\_\_

What are your three main symptoms/concerns?:

1. \_\_\_\_\_ Since when?: \_\_\_\_\_

2. \_\_\_\_\_ Since when?: \_\_\_\_\_

3. \_\_\_\_\_ Since when?: \_\_\_\_\_

**MEDICAL STATUS**

Primary Health Care Practitioner: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Other Physicians Currently Seeing: \_\_\_\_\_

General Health:    Excellent    Good    Fair    Poor    Height: \_\_\_\_\_    Weight: \_\_\_\_\_

Allergies: \_\_\_\_\_    Blood Type: \_\_\_\_\_

Current Diagnosis or Medical Conditions: \_\_\_\_\_

\_\_\_\_\_

Current Medications: \_\_\_\_\_

\_\_\_\_\_

Current Vitamins or OTC Products (please list ALL; you may bring in products at time of evaluation): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current Herbs/etc.: \_\_\_\_\_

Are you currently on Natural Progesterone cream?    Yes    No    If yes, brand name: \_\_\_\_\_

How long have you been on Progesterone cream? \_\_\_\_\_    How much are you using and when? \_\_\_\_\_

Current Hormone Replacement Therapy:    Name: \_\_\_\_\_    Strength: \_\_\_\_\_

Date started: \_\_\_\_\_

How and when do you take current HRT?: \_\_\_\_\_

Previous Hormone Replacement Therapy:    Name: \_\_\_\_\_    Strength: \_\_\_\_\_

Reason for Change: \_\_\_\_\_

Any lab results you may wish to enclose would be helpful for your evaluation.

Exam/Lab Results:

LAB	DATE	SERUM	SALIVA	RESULTS
FSH				
PROGESTERONE				
ESTRIOL (E3)				
ESTRADIOL (E2)				
ESTRONE (E1)				
TESTOSTERONE:				
TOTAL				
FREE				
DHEA SULFATE				
CHOLESTEROL:				
TRIGLYCERIDES				
TOTAL				
HDL				
LDL				

Bone Density: Yes No Date: \_\_\_\_\_ Type: Back Hip T-Score: \_\_\_\_\_

Have you ever had a mammogram?: Yes No Date: \_\_\_\_\_ Results: \_\_\_\_\_

Have you ever had your Thyroid tested?: Yes No Date: \_\_\_\_\_ TSH: \_\_\_\_ T4: \_\_\_\_ Free T3: \_\_\_\_  
Other: \_\_\_\_\_

**CURRENT AND PAST MEDICAL CONDITIONS**

Please check the ones that apply to you:

	Y	N	Date of Diagnosis		Y	N	Date of Diagnosis
Heart Disease				High Blood Pressure			
Stroke				Varicose Veins			
Clotting Defects				Diabetes			
Kidney Trouble				Epilepsy			
Fractures				Arthritis			
Colitis				Gall bladder trouble			
Irritable Bowel				Asthma			
Ulcers				Autoimmune Disorder			
Fibromyalgia				Osteoporosis			
Chronic Fatigue				Cancer			
Eating Disorder							

**HABITS**

Dietary Restrictions: \_\_\_\_\_

Meal Choices: Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Do you get routine exercise?: \_\_\_\_\_ What type?: \_\_\_\_\_ How often?: \_\_\_\_\_

Do you use tobacco products?: Yes No How Much?: \_\_\_\_\_ How Long?: \_\_\_\_\_

Do you use alcohol products?: Yes No How Much?: \_\_\_\_\_ How Long?: \_\_\_\_\_

Do you use caffeine products?: Yes No How Much?: \_\_\_\_\_ How Long?: \_\_\_\_\_

## FAMILY HISTORY

RELATIVE	IMPORTANT DISEASES	LIVING	DECEASED
Mother			
Father			
Brothers			
Sisters			
Aunts			
Uncles			
Paternal Grandmother			
Paternal Grandfather			
Maternal Grandmother			
Maternal Grandfather			

## GYNECOLOGICAL HISTORY

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

Date of last pelvic exam: \_\_\_\_\_ and Pap smear: \_\_\_\_\_ Results: \_\_\_\_\_

Have you ever had an abnormal Pap?: Yes No When?: \_\_\_\_\_ How many times?: \_\_\_\_\_

Treatment: \_\_\_\_\_

Are you sexually active?: Yes No Are you trying to get pregnant?: Yes No

Current birth control method: \_\_\_\_\_ How long?: \_\_\_\_\_

Problem with it: \_\_\_\_\_ How long?: \_\_\_\_\_

Past birth control and related problems: \_\_\_\_\_

Have you ever been on birth control?: Yes No Brand: \_\_\_\_\_ How long on?: \_\_\_\_\_

Side effects: \_\_\_\_\_

**PLEASE FILL OUT NEXT SECTION EVEN IF NOT CYCLING NOW**

How many days from start of one period to the start of next: \_\_\_\_\_

Number of days of flow: \_\_\_\_\_ Amount of bleeding: \_\_\_\_\_

Amount of cramping: \_\_\_\_\_

Premenstrual symptoms: \_\_\_\_\_

Starting and ending when?: \_\_\_\_\_

Any current changes in your normal cycle?: \_\_\_\_\_

**PLEASE FILL OUT THIS SECTION EVEN IF NOT CYCLING NOW**

Any bleeding between periods?: \_\_\_\_\_ When?: \_\_\_\_\_

Any pelvic pain, pressure or fullness?: \_\_\_\_\_ Describe: \_\_\_\_\_

Any unusual vaginal discharge or itching?: \_\_\_\_\_ Describe: \_\_\_\_\_

Treatment: \_\_\_\_\_

Age at first pregnancy: \_\_\_\_\_ How many full term pregnancies?: \_\_\_\_\_

Problems: \_\_\_\_\_

Any interrupted pregnancies? Miscarriages?: Yes No Abortions?: Yes No

Which pregnancy?: \_\_\_\_\_ How far along?: \_\_\_\_\_

Have you had a tubal ligation?: Yes No When?: \_\_\_\_\_ Cycle or symptoms change after?: \_\_\_\_\_

Have you had a hysterectomy?: Yes No When?: \_\_\_\_\_ Why?: \_\_\_\_\_

Symptoms change after hysterectomy?: \_\_\_\_\_

Have you had any part or whole ovary removed?: Yes No When?: \_\_\_\_\_ Why?: \_\_\_\_\_

Symptoms change after?: \_\_\_\_\_

Age mother in menopause?: \_\_\_\_\_

Name of gynecologist \_\_\_\_\_ Phone \_\_\_\_\_

Name of physician who will be authorizing your prescriptions \_\_\_\_\_

Phone number \_\_\_\_\_

Fax number \_\_\_\_\_

### Symptoms List

The following score sheet will help you to determine whether hormone testing is needed, and which tests to order. Each category is divided into hormone deficiency and excess, as each has a different subset of symptoms. Score the symptoms which apply to you as 0 (none), 1 (mild), 2 (moderate), or 3 (severe). A score of 10 or higher in any one category (deficiency and excess combined) is probably worthwhile to test.

#### Estrogens (Estradiol)

##### Estrogen Deficiency

- \_\_\_\_\_ Hot flashes
- \_\_\_\_\_ Night sweats
- \_\_\_\_\_ Vaginal dryness

##### Estrogen Excess

- \_\_\_\_\_ Mood Swings (PMS)
- \_\_\_\_\_ Tender breasts
- \_\_\_\_\_ Water retention

- Foggy thinking
- Memory lapses
- Incontinence
- Tearful
- Depressed
- Sleep disturbances
- Heart palpitation
- Bone loss

- Nervous
- Irritable
- Anxious
- Fibrocystic breasts
- Uterine fibroids
- Weight gain in hips
- Bleeding changes
- Headaches

### Progesterone

#### Progesterone Deficiency

- Hot flashes
- Night sweats
- Vaginal dryness
- Foggy thinking
- Memory lapses
- Incontinence
- Tearful
- Depressed
- Sleep disturbances
- Heart palpitation
- Bone loss

#### Progesterone Excess

- Sleepiness
- Breast swelling/tenderness
- Decreased libido
- Mild depression
- Candida infections

### Androgens (DHEA and Testosterone)

#### Androgen Deficiency

- Low libido
- Vaginal dryness
- Foggy thinking
- Fatigue
- Aches/pains
- Memory lapses
- Incontinence
- Depressed
- Sleep disturbances
- Bone loss
- Decreased muscle mass
- Thinning skin

#### Androgen Excess

- Excessive facial/body hair
- Loss of scalp hair
- Increased acne
- Oily skin

### Cortisol

#### Cortisol Deficiency

- Fatigue
- Sugar craving
- Allergies
- Chemical sensitivity
- Stress
- Cold body temperature
- Heart palpitations
- Aches/pains
- Arthritis

#### Cortisol Excess

- Sleep disturbances
- Bone loss
- Fatigue
- Weight gain in waist
- Loss of muscle mass
- Thinning skin

## SYMPTOMS PART I

Rate your current status for each symptom by checking the appropriate column.

Symptom	Absent	Mild	Moderate	Severe
Vaginal Dryness				
Shortness of Breath				
Dry Hair/Skin				
Hair Loss				
Short Term Memory Loss				
Frequent UTIs				
Heart Palpitations				
Frequent Yeast Infections				
Painful Intercourse				
Inability to Reach Orgasm				
Tearful (crying easily)				
Food Cravings				
Irritability/Moodiness				
Cramps				
Hot Flashes				
Night Sweats				
Weight Gain				
Bloating				
Memory Lapses				
Allergies				
Chemical Sensitivity				
Stress				
Aches & Pains				
Arthritis				
Loss of Muscle Mass				
Thinning Skin				
Recurrent Sinus Infections				
Asthma/Bronchitis				
Incontinence				

Excessive Facial/Body Hair				
Loss of Scalp Hair				
Increased Acne				
Oily Skin				

## SYMPTOMS PART II

Rate your current status for each symptom by checking the appropriate column.

Symptom	Absent	Mild	Moderate	Severe
Fluid Retention (Edema)				
Afternoon Fatigue				
Breast Swelling				
Breast Tenderness (Frontal)				
Fibrocystic Breast(s)				
Uterine Fibroids				
Mood Swings				
Heavy/Irregular Menses				
Loss of Sex Drive				
Headaches (Cyclical)				
Weight Gain in Hips/Thighs				
Anxious/Nervous				
Sensitive				
Sweet Cravings				
Salt Cravings				
Constipation				
Cold Hands & Feet				
Low Body Temperature				
Dry Skin & Hair				
"Fuzzy" Thinking				
Fatigue Upon Arising				
Infertility				
Fibromyalgia				

**Please provide a brief description of your medical history in your own words:**

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