

Healthway Compounding Pharmacy  
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Saginaw, MI 48604  
989/791-1691  
Toll Free: 866-883-8866  
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Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Name: \_\_\_\_\_

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

City: \_\_\_\_\_

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

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Gender: \_\_\_\_ Male \_\_\_\_ Female

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

How often and how much? \_\_\_\_\_

Do you use tobacco? \_\_\_\_ Yes \_\_\_\_ No

Do you use alcohol? \_\_\_\_ Yes \_\_\_\_ No

Do you use caffeine? \_\_\_\_ Yes \_\_\_\_ No

Doctor's Name: \_\_\_\_\_

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

Phone: \_\_\_\_\_

Allergies: Please check all that apply

\_\_\_\_ Penicillin \_\_\_\_ morphine \_\_\_\_ dye allergies \_\_\_\_ seasonal (pollen) allergies

\_\_\_\_ Codeine \_\_\_\_ aspirin \_\_\_\_ nitrate allergy \_\_\_\_ no known allergies

\_\_\_\_ sulfa drugs \_\_\_\_ food allergies \_\_\_\_ pet allergies \_\_\_\_ other: \_\_\_\_\_

Please describe the allergic reaction you experienced and when it occurred.

Over-the-counter (OTC) issues: Please check all products that you used occasionally or regularly.

\_\_\_\_ pain reliever \_\_\_\_ combination products (cough & cold reliever, Triaminic DM®)

\_\_\_\_ aspirin \_\_\_\_ sleep aids (Excedrin PC®, Unisom®, Sominex®, Nytol®)

\_\_\_\_ acetaminophen (Tylenol®) \_\_\_\_ antidiarrheals (Imodium®, Pepto Bismol®, Kaopectate®)

\_\_\_\_ ibuprofen (Motrin IB®) \_\_\_\_ Laxatives / stool softener (Doxidan®, Correctol®)

\_\_\_\_ naproxen (Aleve®) \_\_\_\_ Diet aids / weight loss products (Dexatril®)

\_\_\_\_ ketoprofen (Orudis KT®) \_\_\_\_ antacids (Maalox®, Mylanta®)

\_\_\_\_ cough suppressant (Robitussin DM®) \_\_\_\_ acid blockers (Tagament HB®, Pepcid C®, Zantac 75®)

\_\_\_\_ antihistamine (Benadryl, Cholr-Trimeton®) \_\_\_\_ others: \_\_\_\_\_

\_\_\_\_ decongestant (Sudafed®)

Nutritional / Natural Supplements: Please check the products you are using.

\_\_\_\_ vitamins (multiple or single vitamins, i.e. B complex, E, C, carotene)

\_\_\_\_ minerals (calcium, magnesium, chromium, colloidal minerals, single minerals)

\_\_\_\_ herbs (Ginseng, Ginkgo Biloba, Echinacea, herbal medicinal teas, tinctures, etc.)

\_\_\_\_ enzymes (digestive formulas, papaya, bromelain, CoEnzyme Q10, etc.)

\_\_\_\_ nutrition / protein supplements ( shark cartilage, protein powders, amino acids, fish oils)

\_\_\_\_ others (glucosamine, etc.): \_\_\_\_\_

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

- |   |  |
|---|--|
| <input type="checkbox"/> Heart disease (e.g. congestive heart failure)    | <input type="checkbox"/> Blood clotting problems           |
| <input type="checkbox"/> High cholesterol or lipids (e.g. hyperlipidemia) | <input type="checkbox"/> Diabetes                          |
| <input type="checkbox"/> High blood pressure (e.g. hypertension)          | <input type="checkbox"/> Arthritis or joint problems       |
| <input type="checkbox"/> Cancer   | <input type="checkbox"/> Depression                        |
| <input type="checkbox"/> Ulcers (e.g. stomach, esophagus)                 | <input type="checkbox"/> Epilepsy                          |
| <input type="checkbox"/> Thyroid disease                                  | <input type="checkbox"/> Headaches/migraines               |
| <input type="checkbox"/> Hormonal related issues                          | <input type="checkbox"/> Eye disease (e.g. glaucoma, etc.) |
| <input type="checkbox"/> Lung conditions (e.g. asthma, emphysema, COPD)   | <input type="checkbox"/> Other: _____                      |
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Current Prescription Medications:

Medication Name	Strength	Date Started	How often per day
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Hormones previously taken	Date Started	Date Stopped	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Bone Size:  Small  Medium  Large

Body Type:  Androgenic (larger upper body compared to lower body)  
 Estrogenic (smaller upper body compared to lower body)  
 Equally distributed proportions

Have you ever used oral contraceptives?  Yes  No  
If yes, any problems using oral contraceptives?  Yes  No  
Please describe: \_\_\_\_\_

How many pregnancies have you had? \_\_\_\_\_ How many children? \_\_\_\_\_  
Any interrupted pregnancies?  No  Yes  
Have you had a hysterectomy?  No  Yes (date of surgery) \_\_\_\_\_  
Ovaries removed?  No  Yes  
Have you had a tubal ligation?  No  Yes

Do you have a family history of any of the following?

Uterine cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Family member(s)	_____
Ovarian cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Family member(s)	_____
Fibrocystic breast	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Family member(s)	_____
Breast cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Family member(s)	_____
Heart disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Family member(s)	_____
Osteoporosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Family member(s)	_____

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Have you had any of the following tests performed? Please check all that apply and not date

Mammogram  No  Yes Date: \_\_\_\_\_  
Pap Smear  No  Yes Date: \_\_\_\_\_

Since you first began having menses, have you ever had what YOU would consider to be abnormal cycles?  
 No  Yes

If yes, please explain your symptoms and at what age(s) this occurred:

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When was your last cycle? \_\_\_\_\_

How many days did it last? \_\_\_\_\_

Do you have, or have you ever had Premenstrual Syndrome (PMS)?  No  Yes

If yes, please explain symptoms:

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Please indicate your symptoms for the following conditions:

	ABSENT	MILD	MODERATE	SEVERE
Fibrocystic Breast	_____	_____	_____	_____
Weight Gain	_____	_____	_____	_____
Heavy/Irregular menses	_____	_____	_____	_____
Hot Flashes	_____	_____	_____	_____
Dry Skin / Hair	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Night Sweats	_____	_____	_____	_____
Vaginal Dryness	_____	_____	_____	_____
Headaches	_____	_____	_____	_____
Irritability	_____	_____	_____	_____
Mood Swings	_____	_____	_____	_____
Breast Tenderness	_____	_____	_____	_____
Sleep Disturbances / Insomnia	_____	_____	_____	_____
Cramps	_____	_____	_____	_____
Fluid Retention	_____	_____	_____	_____
Breakthrough Bleeding	_____	_____	_____	_____
Fatigue	_____	_____	_____	_____
Memory Loss	_____	_____	_____	_____
Incontinence/frequent urination	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Difficulty reaching orgasm	_____	_____	_____	_____
Decreased libido	_____	_____	_____	_____
Hair Loss	_____	_____	_____	_____

How did you arrive at the decision to consider bio-identical hormone replacement (BHRT)?

Doctor  Self  Friend/family member  Other



