Healthway Compounding Pharmacy
2544 McLeod Dr. N., Ste. 2
Saginaw, MI 48604
989-791-1691
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Hormone Consultation for Women

Today's Date: _____/_____/_____
Patient Name: _____ Birth date: _____/_____/_____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Email: _____

Martial Status _____ Married _____ Single _____ Widowed
Occupation _____
Height: _____ Weight: _____

Allergies: Please check all that apply

_____ Penicillin _____ morphine _____ dye allergies _____ Codeine
_____ aspirin _____ nitrate allergy _____ sulfa drugs _____ food allergies
_____ pet allergies _____ seasonal (pollen) allergies other: _____

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

_____
_____
_____

Bone Size: _____ Small _____ Medium _____ Large

Doctor's Name:	Address:	Phone:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

_____ Doctor _____ Self _____ Friend/family member _____ Other

Current Prescription Medications/Current Nutritional Supplements:
(Please bring any nutritional supplements you take to your consultation)

Name	Strength	Date Started	How often per day

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

_____ pain reliever
_____ sleep aids
_____ antidiarrheals
_____ Laxative / stool softener
_____ Diet aids / weight loss products
_____ antacids
_____ others: _____

	How often and how much?
Do you use tobacco? _____ Yes _____ No	_____
Do you use alcohol? _____ Yes _____ No	_____
Do you use caffeine? _____ Yes _____ No	_____

Hormones previously taken	Date Started	Date Stopped	Reason

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

_____
_____

Have you had any of the following tests performed in the last year?
Please check all that apply and note date

				Normal:
Mammogram	□ No	□Yes	Date: _____	□ Yes □ No
Pap Smear	□ No	□Yes	Date: _____	□ Yes □ No

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:

_____
_____
_____

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:

_____
_____
_____

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

Medical Conditions / Diseases: Please check all that apply to you or an immediate family member.

Self	Family		Self	Family	
□	□	Allergies	□	□	Heart Disease
□	□	Alzheimer's	□	□	High Cholesterol or Lipids
□	□	Arthritis	□	□	High Blood Pressure
□	□	Asthma	□	□	Eye Disease
□	□	Cancer: _____	□	□	Migraines/headaches
□	□	Clotting Problems	□	□	Osteoporosis
□	□	Depression	□	□	Thyroid Disease
□	□	Diabetes	□	□	Ulcer
□	□	Eczema	□	□	Emphysema/COPD
□	□	Fibrocystic breast	□	□	Fibromyalgia
□	□	Ulcers	□	□	GERD
□	□	Anxiety Disorder	□	□	Seizure Disorder
□	□	Stroke	□	□	Irritable Bowel
□	□	Other: _____	□	□	Other: _____
□	□	Other: _____	□	□	Other: _____

Please indicate your symptoms for the following conditions by using the following numeric scale:
0 being no symptoms at all up to 5 being the worst symptoms imaginable

Fibrocystic Breast	0	1	2	3	4	5
Weight Gain	0	1	2	3	4	5
Heavy/Irregular menses	0	1	2	3	4	5
Hot Flashes	0	1	2	3	4	5
Dry Skin / Hair	0	1	2	3	4	5
Anxiety	0	1	2	3	4	5
Depression	0	1	2	3	4	5
Night Sweats	0	1	2	3	4	5
Vaginal Dryness	0	1	2	3	4	5
Headaches	0	1	2	3	4	5
Irritability	0	1	2	3	4	5
Mood Swings	0	1	2	3	4	5
Breast Tenderness	0	1	2	3	4	5
Sleep Disturbances/Insomnia	0	1	2	3	4	5
Cramps	0	1	2	3	4	5
Fluid Retention	0	1	2	3	4	5
Breakthrough Bleeding	0	1	2	3	4	5
Fatigue	0	1	2	3	4	5
Memory Loss	0	1	2	3	4	5
Incontinence/frequent urination	0	1	2	3	4	5
Arthritis	0	1	2	3	4	5
Difficulty reaching orgasm	0	1	2	3	4	5
Decreased libido	0	1	2	3	4	5
Hair Loss	0	1	2	3	4	5

What are your goals with taking BHRT?

_____
_____
_____
_____

Please write down any specific questions you have about BHRT.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I understand that my hormone consultation at Healthway Compounding Pharmacy is with a pharmacist who specializes in hormone therapy

- Who will NOT diagnose or treat any medical condition
- Who will NOT replace the advice or my primary care physician in any way,
- Who will work with my referring health care provider to alleviate my hormone related symptoms
- And, who will help me to decide what nutritional supplements, if any, would be safe and appropriate

Name (please print): _____

Signature: _____ Date: _____

Please fax or send this completed questionnaire to:

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