

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: _____

Marital 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

Mammogram No Yes

Date: _____

Normal:

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

- | | | | | | |
|--------------------------|--------------------------|--------------------|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Alzheimer's | <input type="checkbox"/> | <input type="checkbox"/> | High Cholesterol or Lipids |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Eye Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer: _____ | <input type="checkbox"/> | <input type="checkbox"/> | Migraines/headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Clotting Problems | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Ulcer |
| <input type="checkbox"/> | <input type="checkbox"/> | Eczema | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema/COPD |
| <input type="checkbox"/> | <input type="checkbox"/> | Fibrocystic breast | <input type="checkbox"/> | <input type="checkbox"/> | Fibromyalgia |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | GERD |
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety Disorder | <input type="checkbox"/> | <input type="checkbox"/> | Seizure Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Irritable Bowel |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ | <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ | <input type="checkbox"/> | <input type="checkbox"/> | 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 of 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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