

Healthway Compounding Pharmacy  
2544 McLeod Dr. N., Ste. 2  
Saginaw, MI 48604  
989-791-1691  
Toll Free: 866-883-8868  
Fax: 989-791-4603



## 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.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 use once or more per month.

- \_\_\_\_\_ 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	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date: _____	Normal:
Pap Smear	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> 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:

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

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
Indigestion	0	1	2	3	4	5
Cold hands/feet	0	1	2	3	4	5
Diarrhea and/or constipation	0	1	2	3	4	5

What are your goals with taking BHRT?

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Please write down any specific questions you have about BHRT.

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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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