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.

____
____
____

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

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

____
____
____
____

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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