



**“Customized, Patient Specific, Compounded Medications”**

## Confidential BHRT Evaluation

*From a clinical management point of view, it is very useful to gain a detailed history of possible hormone deficiencies. The answers provided in the questions below will allow the pharmacist to maintain your medical history and will help in advising about current medical therapies. All information provided will be kept confidential.*

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

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

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

Phone: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

Full time \_\_\_\_\_ Part-time \_\_\_\_\_ Retired \_\_\_\_\_ Unemployed \_\_\_\_\_ Other \_\_\_\_\_

Living Situation: Spouse \_\_\_\_\_ Partner \_\_\_\_\_ Friend(s) \_\_\_\_\_ Parents \_\_\_\_\_ Children \_\_\_\_\_ Other \_\_\_\_\_

Status: Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

Pets: \_\_\_\_\_

How did you hear about natural hormone replacement therapy? Ad \_\_\_\_\_ Another Patient \_\_\_\_\_

Course/Seminar \_\_\_\_\_ Physician/Health Care Practitioner \_\_\_\_\_ Books/Articles \_\_\_\_\_ Other \_\_\_\_\_

Do you understand what natural hormone replacement is? \_\_\_\_\_

What are your goals for Natural Hormone Replacement? \_\_\_\_\_

\_\_\_\_\_

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**MEDICAL STATUS**

**General Health:**    **Excellent**\_\_\_\_\_ **Good**\_\_\_\_\_ **Fair**\_\_\_\_\_ **Poor**\_\_\_\_\_

**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:** \_\_\_\_\_

**Current Diagnosis or Medical Conditions:** \_\_\_\_\_

**Allergies:**    Please check all that apply.

\_\_\_\_\_ penicillin    \_\_\_\_\_ morphine    \_\_\_\_\_ dye allergies    \_\_\_\_\_ pet allergies

\_\_\_\_\_ codeine    \_\_\_\_\_ aspirin    \_\_\_\_\_ nitrate allergies    \_\_\_\_\_ seasonal (pollen) allergies

\_\_\_\_\_ sulfa drug    \_\_\_\_\_ food allergies    \_\_\_\_\_ no known allergies

other: \_\_\_\_\_

**Please describe the allergic reaction you experienced and when it occurred?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Medications (how often per day)** \_\_\_\_\_

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**Over-the-counter (OTC) issues:** Please check all products that you use occasionally or regularly. **Check all that apply.**

- \_\_\_\_\_ Pain Reliever      \_\_\_\_\_ Combination product (cough+cold reliever) (ex: Triaminic DM®)
- \_\_\_\_\_ Aspirin      \_\_\_\_\_ Sleep aids (ex: Excedrin PC®, Unisom®, Sominex®, Nytol®)
- \_\_\_\_\_ Acetaminophen (example: Tylenol®)      \_\_\_\_\_ Antidiarrheals (ex: Imodium®, Pepto Bismol®, Kaopectate®)
- \_\_\_\_\_ Ibuprofen (example: Motrin IB®)      \_\_\_\_\_ Laxatives/stool softeners (examples: Doxidan®, Correctol®, etc.)
- \_\_\_\_\_ Naproxen (example: Aleve®)      \_\_\_\_\_ Diet aids/weight loss products (example: Dexatril®)
- \_\_\_\_\_ Ketoprofen (example: Orudis KT®)      \_\_\_\_\_ Antacids (examples: Maalox®, Mylanta®)
- \_\_\_\_\_ Cough suppressant (ex: Robitussin DM®)      \_\_\_\_\_ Acid blockers (ex: Tagamet HB®, Pepcid®, Zantac 75®)
- \_\_\_\_\_ Antihistamine product (example: Chlor-Trimeton®)      \_\_\_\_\_ Decongestant product (example: Sudafed®)

Other (please list): \_\_\_\_\_

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**Nutritional/Natural Supplements:** Please identify the products used.

- \_\_\_\_\_ Vitamins (examples: multiple or single vitamins such as B complex, E, C, beta carotene)
- \_\_\_\_\_ Minerals (examples: calcium, magnesium, chromium, colloidal minerals, various single minerals)
- \_\_\_\_\_ Herbs (examples: Ginseng, Ginkgo Biloba, Echinacea, other herbal medicinal teas, tinctures, remedies, etc.)
- \_\_\_\_\_ Enzymes (examples: digestive formulas, papaya, bromelain, CoEnzyme Q10, etc.)
- \_\_\_\_\_ Nutrition/protein supplements (examples: shark cartilage, protein powders, amino acids, fish oils, etc.)
- \_\_\_\_\_ Others (glucosamine, etc.) \_\_\_\_\_

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

\_\_\_\_\_ Heart disease (example: Congestive Heart Failure) \_\_\_\_\_ Blood Clotting Problems  
\_\_\_\_\_ High cholesterol or lipids (examples: Hyperlipidemia) \_\_\_\_\_ Diabetes  
\_\_\_\_\_ High blood pressure (example: Hypertension) \_\_\_\_\_ Arthritis or joint problems  
\_\_\_\_\_ Cancer \_\_\_\_\_ Depression \_\_\_\_\_ Varicose Veins \_\_\_\_\_ Kidney Trouble \_\_\_\_\_ Fractures  
\_\_\_\_\_ Arthritis \_\_\_\_\_ Colitis \_\_\_\_\_ Gallbladder Trouble \_\_\_\_\_ Asthma \_\_\_\_\_ Chronic Fatigue  
\_\_\_\_\_ Fibromyalgia \_\_\_\_\_ Eating Disorder \_\_\_\_\_ Cancer \_\_\_\_\_ Ulcers (stomach, esophagus) \_\_\_\_\_ Epilepsy  
\_\_\_\_\_ Thyroid disease \_\_\_\_\_ Headaches/migraine \_\_\_\_\_ Hormonal Related Issues \_\_\_\_\_ Eye Disease (glaucoma, etc)  
\_\_\_\_\_ Lung condition (example: asthma, emphysema, COPD)

Other: Please list: \_\_\_\_\_

**Habits:** \_\_\_\_\_

**Dietary Restrictions:** \_\_\_\_\_

**Meal Choices:**

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

**Do you get routine physical exercise?** \_\_\_\_\_ **What type?** \_\_\_\_\_

**GYNECOLOGICAL HISTORY**

**List Hormones previously taken.**    Date Started / Date Stopped / Reason

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Bone Size:                    \_\_\_\_\_ Small                    \_\_\_\_\_ Medium                    \_\_\_\_\_ Large

Have you ever used oral contraceptives?                    \_\_\_\_\_ No                    \_\_\_\_\_ Yes

Any problems?                    \_\_\_\_\_ No                    \_\_\_\_\_ Yes

If YES, describe any problem(s).

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How many pregnancies have you had? \_\_\_\_\_                    How many children \_\_\_\_\_

Age at first pregnancy: \_\_\_\_\_

Any problems with pregnancies? \_\_\_\_\_  
\_\_\_\_\_

Any interrupted pregnancies? (miscarriage or abortion)                    \_\_\_\_\_ No                    \_\_\_\_\_ Yes

Have you had a hysterectomy?                    \_\_\_\_\_ No                    \_\_\_\_\_ Yes    (Date of Surgery) \_\_\_\_\_

Have you had any part or whole ovary removed?                    \_\_\_\_\_ No                    \_\_\_\_\_ Yes

Have you had a tubal ligation?                    \_\_\_\_\_ No                    \_\_\_\_\_ Yes    (Date) \_\_\_\_\_

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

Uterine Cancer \_\_\_\_\_                    Family member(s) \_\_\_\_\_

Ovarian Cancer \_\_\_\_\_                    Family member(s) \_\_\_\_\_

Fibrocystic breast \_\_\_\_\_ Family member(s) \_\_\_\_\_  
Breast Cancer \_\_\_\_\_ Family member(s) \_\_\_\_\_  
Heart Disease \_\_\_\_\_ Family member(s) \_\_\_\_\_  
Osteoporosis \_\_\_\_\_ Family member(s) \_\_\_\_\_  
Diabetes \_\_\_\_\_ Family member (s) \_\_\_\_\_

**Have you had any of the following tests performed? Check those that apply and note date of last test.**

Mammography \_\_\_\_\_ No \_\_\_\_\_ Yes Date: \_\_\_\_\_  
PAP Smear \_\_\_\_\_ No \_\_\_\_\_ Yes Date: \_\_\_\_\_  
Pelvic Exam \_\_\_\_\_ No \_\_\_\_\_ Yes Date: \_\_\_\_\_

Results: \_\_\_\_\_

Have you ever had an abnormal pap? \_\_\_\_\_ Treatment: \_\_\_\_\_

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

If YES, please explain (such as age when this occurred, symptoms....):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Age at first Period: \_\_\_\_\_ When was your last period? \_\_\_\_\_

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

Do you have, or did you ever have Premenstrual Syndrome (PMS)? \_\_\_\_\_ No \_\_\_\_\_ Yes

If YES, explain symptoms: \_\_\_\_\_

\_\_\_\_\_

Are you sexually active? \_\_\_\_\_ Are you trying to get pregnant? \_\_\_\_\_

Current Birth Control Method: \_\_\_\_\_ How Long? \_\_\_\_\_

Past Birth Control and any related problems: \_\_\_\_\_

How many days from start of one period to start of the next? \_\_\_\_\_

Number of days of flow: \_\_\_\_\_ Amount of bleeding: \_\_\_\_\_

Amount of Cramps: \_\_\_\_\_

Premenstrual Symptoms: \_\_\_\_\_

Starting and ending when: \_\_\_\_\_

Any current changes in your normal cycle: \_\_\_\_\_

Any bleeding between periods: \_\_\_\_\_ When? \_\_\_\_\_

Any pelvic pain, pressure or fullness? \_\_\_\_\_ Describe: \_\_\_\_\_

\_\_\_\_\_

Any unusual vaginal discharge or itching? \_\_\_\_\_ Describe: \_\_\_\_\_

\_\_\_\_\_

Treatment: \_\_\_\_\_

**How did you arrive at the decision to consider Bio-Identical Hormone Replacement Therapy?**

Doctor \_\_\_\_\_ Self \_\_\_\_\_ Friend/Family \_\_\_\_\_ Member \_\_\_\_\_ Other \_\_\_\_\_

**What are your goals with taking BHRT?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



# HORMONE REPLACEMENT THERAPY PATIENT INFORMATION SHEET

	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 Disturbance/Insomnia	_____	_____	_____	_____
Cramps	_____	_____	_____	_____
Fluid Retention	_____	_____	_____	_____
Breakthrough Bleeding	_____	_____	_____	_____
Fatigue	_____	_____	_____	_____
Loss of Memory	_____	_____	_____	_____
Bladder Symptoms	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Harder to Reach Climax	_____	_____	_____	_____

	<b>ABSENT</b>	<b>MILD</b>	<b>MODERATE</b>	<b>SEVERE</b>
Decreased Sex Drive	_____	_____	_____	_____
Hair Loss	_____	_____	_____	_____
Low Libido	_____	_____	_____	_____
Swollen Breasts	_____	_____	_____	_____
Moodiness	_____	_____	_____	_____
Fuzzy Thinking	_____	_____	_____	_____
Food Cravings	_____	_____	_____	_____
Bloating	_____	_____	_____	_____
Shortness of breath	_____	_____	_____	_____
Heart Palpitations	_____	_____	_____	_____
Frequent Yeast Infections	_____	_____	_____	_____
Vaginal Shrinking	_____	_____	_____	_____
Loss of Pubic Hair	_____	_____	_____	_____
Painful Intercourse	_____	_____	_____	_____
Weight Gain (Hips/Thighs)	_____	_____	_____	_____
Symptoms of Low Thyroid	_____	_____	_____	_____

