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PHARMACY

Confidential Hormone Evaluation

Date: _____

Name: _____ Birthdate: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ (home) _____ (other)

Gender: Female Male Height: _____ Weight: _____

Medical History:

Current Providers:

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

Allergies: Please check all that apply

___ Penicillin ___ Morphine ___ Dyes ___ Pets
___ Codeine ___ Aspirin ___ Nitrates ___ Seasonal (pollen)
___ Sulfa drugs ___ Food allergies Other: _____ ___ None

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

Medical Conditions/Diseases: Please check all that apply

___ Heart Disease ___ Blood Clotting Problems
___ High cholesterol or lipids ___ Diabetes
___ High blood pressure ___ Arthritis or joint problems
___ Cancer ___ Depression
___ Ulcers ___ Epilepsy
___ Thyroid Disease ___ Headaches/Migraines
___ Hormonal Related Issues ___ Eye Disease
___ Lung Conditions (asthma, COPD) ___ Other: _____

Medical History (Continued)

How many pregnancies have you had? _____ How many children? _____

Any interrupted pregnancies? (yes/no) _____ Date(s): _____

Have you ever had a hysterectomy or removal of ovaries? (if yes, please state which one and date of surgery) _____

When was your last period? _____

How many days did it last? _____

Do you have, or did you ever have Premenstrual Syndrome (PMS)? (yes/no) _____

If yes, please explain symptoms: _____

Since you first began having periods, have you ever had what YOU consider to be abnormal cycles? (yes/no) _____ Date(s): _____

If yes, please explain (such as age this occurred, symptoms, ect.):

Have you had any of the following tests performed?

Mammography (yes/no) _____ Date of last test: _____
PAP Smear (yes/no) _____ Date of last test: _____

Family History:

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

	Yes/No	Family Member(s)
Uterine Cancer	_____	_____
Ovarian Cancer	_____	_____
Fibrocystic breast	_____	_____
Breast Cancer	_____	_____
Heart Disease	_____	_____
Osteoporosis	_____	_____

Medication History:

Tobacco use? Yes No How much and how often? _____
Alcohol use? Yes No _____
Caffeine use? Yes No _____

Over the counter (OTC) products:

Please list any OTC drugs you use occasionally or regularly:
Examples include: Pain relievers (Tylenol, Advil), Cough and Cold (Sudafed, Robitussin), Sleep Aids (Tylenol PM), Antidiarrheals, Laxatives, Diet aids (Dexatril), Heartburn medications (Tums, Zantac 75, Pepsid AC, Prilsec OTC).

Nutritional/Natural Supplements:

Please list any supplements you are using. These include **Vitamins** (multi-vitamin, B, C, D, beta carotene), **Minerals** (calcium, magnesium, chromium), **Herbs** (ginseng, echinacea, ginkgo biloba), **Enzymes** (Co-Q10, digestive formulas), **Nutritional** (Protein, amino acids, fish oils)

Current Prescription Medications:

Name:	Strength:	How often per day?	Date started:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Hormones previously taken:	Date started	Date ended	Reason for stopping
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever used oral contraceptives? (yes/no) _____
 Have you experienced any problems with these? (yes/no) _____
 If yes, please describe any problem(s): _____

Hormone Replacement Therapy Patient Information Sheet:

Please check the category that best applies to you.

	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 Disturbances/Insomnia	_____	_____	_____	_____
Cramps	_____	_____	_____	_____
Fluid Retention	_____	_____	_____	_____
Breakthrough Bleeding	_____	_____	_____	_____
Fatigue	_____	_____	_____	_____
Loss of Memory	_____	_____	_____	_____
Bladder Symptoms	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Harder to Reach Climax	_____	_____	_____	_____
Decreased Sex Drive	_____	_____	_____	_____
Hair Loss	_____	_____	_____	_____

