



*Natural Hormone Replacement
Confidential Evaluation©*

International Academy of Compounding Pharmacists

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.

GENERAL INFORMATION

Date: _____

Name: _____ Age: _____ Birth Date: _____

Address: _____

Home Phone _____ Work Phone _____ Cell Phone _____

Occupation: _____ Full-time _____ Part-Time _____ Retired _____ Unemployed _____ Other _____

Living Situation: Spouse _____ Alone _____ Partner _____ Friend(s) _____ Parents _____ Children _____ Other _____

Status: Married _____ Single _____ Divorced _____ Widowed _____

Pets: _____

How did you hear about Natural Hormone Replacement Therapy: Ad _____ Another Patient _____ Courses/Seminars _____

Physician/Healthcare Practitioner _____ Books/Articles _____ Other _____

Do you understand what Natural Hormone Replacement is: _____

What are your goals for Natural Hormone Replacement: _____

MEDICAL STATUS

General Health: Excellent _____ Good _____ Fair _____ Poor _____ Height _____ Weight _____

Current Diagnosis or medical conditions: _____

Drug Allergies: _____

Allergies to food, pollens, etc: _____

Current Medications: _____

Current Vitamins or OTC products: _____

Current Herbs/etc.: _____

Have you ever had your cholesterol level checked: _____ Date: _____ Results: _____

Have you ever had a mammogram: _____ Date: _____ Results: _____

Have you ever had a bone density scan: _____ Date: _____ Results: _____
Current/Recent Health Care Providers: _____

PAST MEDICAL CONDITIONS

Childhood diseases: _____

Heart Trouble _____ Stroke _____ High Blood Pressure _____ Varicose Veins _____
Clotting Defects _____ Diabetes _____ Kidney Trouble _____ Epilepsy _____ Fractures _____
Arthritis _____ Colitis _____ Gallbladder Trouble _____ Chronic Fatigue _____ Asthma _____
Fibromyalgia _____ Cancer _____ Eating Disorder _____

HABITS

Dietary Restrictions: _____

Meal Choices: Breakfast _____
Lunch: _____
Dinner: _____

Do you get routine physical exercise: _____ What type: _____

Do you use tobacco products: _____ How much: _____ Previously _____ How long _____

Do you use alcohol products: _____ How much: _____ Previously _____ How long _____

Do you use caffeine products: _____ How much: _____

FAMILY HISTORY

Please list family members and their age which are still living that may have important diseases such as High Blood Pressure, Heart Disease, Cancer, Diabetes, Osteoporosis, etc.: _____

Please list family members who died of important diseases (see above question) and their age at the time of their death: _____

GYNECOLOGICAL HISTORY

Age at first period: _____ Date of last period: _____

Date of last pelvic exam: _____ and Papsmear: _____ Results: _____

Have you ever had an abnormal pap? _____ Treatment: _____

Are you sexually active? _____ Are you trying to get pregnant? _____
 Current birth control method: _____
 Problem with it: _____ How long: _____
 Past birth control and any related problems: _____
 How many days from start of one period to the 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: _____
 Age at first pregnancy: _____
 How many full term pregnancies? _____ Problems: _____

 Any interrupted pregnancies? (miscarriages or abortions) _____
 Have you had a tubal ligation? _____ When? _____
 Have you had any part or whole ovary removed? _____
 Have you had a hysterectomy? _____ When? _____
 Do your ovaries remain? _____

SYMPTOMS I

Rate your current status for each symptom by checking the appropriate modifier. Please feel free to use additional space to describe any symptom. This section may be repeated upon subsequent visits.

	Absent	Mild	Moderate	Severe
1. Headaches	_____	_____	_____	_____
2. Low Libido	_____	_____	_____	_____
3. Anxiety	_____	_____	_____	_____
4. Swollen Breast	_____	_____	_____	_____
5. Moodiness	_____	_____	_____	_____
6. Fuzzy Thinking	_____	_____	_____	_____
7. Depression	_____	_____	_____	_____
8. Food Cravings	_____	_____	_____	_____
9. Irritability	_____	_____	_____	_____
10. Insomnia	_____	_____	_____	_____
11. Cramps	_____	_____	_____	_____
12. Emotional Swings	_____	_____	_____	_____
13. Painful Breasts	_____	_____	_____	_____
14. Weight Gain	_____	_____	_____	_____
15. Bloating	_____	_____	_____	_____
16. Inability to Concentrate	_____	_____	_____	_____

SYMPTOMS II

Rate your current status for each symptom by checking the appropriate modifier. Please feel free to use additional space to describe any symptom. This section may be repeated on subsequent visits.

	Absent	Mild	Moderate	Severe
1. Hot Flashes	_____	_____	_____	_____
2. Shortness of Breath	_____	_____	_____	_____
3. Night Sweats	_____	_____	_____	_____
4. Sleep Disorders, Insomnia	_____	_____	_____	_____
5. Vaginal Dryness	_____	_____	_____	_____
6. Dry Hair/Skin	_____	_____	_____	_____
7. Hair Loss	_____	_____	_____	_____
8. Anxiety	_____	_____	_____	_____
9. Mood Swings	_____	_____	_____	_____
10. Headaches	_____	_____	_____	_____
11. Depression	_____	_____	_____	_____
12. Short Term Memory Loss	_____	_____	_____	_____
13. Frequent Urinary Tract Infections	_____	_____	_____	_____
14. Heart Palpitations	_____	_____	_____	_____
15. Frequent Yeast Infections	_____	_____	_____	_____
16. Vaginal Shrinking	_____	_____	_____	_____
17. Loss of Pubic Hair	_____	_____	_____	_____
18. Painful Intercourse	_____	_____	_____	_____
19. Inability to Reach Orgasm	_____	_____	_____	_____

SYMPTOMS III

Rate your current status for each symptom by checking the appropriate modifier. Please feel free to use additional space to describe any symptom. This section may be repeated on subsequent visits.

1. Water Retention, Edema	_____	_____	_____	_____
2. Fatigue, Lack of Energy	_____	_____	_____	_____
3. Breast Swelling	_____	_____	_____	_____
4. Fibrocystic Breasts	_____	_____	_____	_____
5. Premenstrual Mood Swings	_____	_____	_____	_____
6. Loss of Sex Drive	_____	_____	_____	_____
7. Heavy or Irregular Menses	_____	_____	_____	_____

FEMALE Symptom Checklist

Use each of the following checklists to determine your symptoms of hormone imbalance and to help you choose the appropriate hormone test profile.

Category 1: Basic Hormone Imbalance

Mark which of the following symptoms are troublesome and/or persist over time.

<input type="checkbox"/> Hot flashes	<input type="checkbox"/> Mood swings (PMS)	<input type="checkbox"/> Urinary incontinence	<input type="checkbox"/> Night sweats
<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Cystic ovaries	<input type="checkbox"/> Vaginal dryness	<input type="checkbox"/> Acne
<input type="checkbox"/> Heavy menses	<input type="checkbox"/> Foggy thinking	<input type="checkbox"/> Weight gain	<input type="checkbox"/> Depressed mood
<input type="checkbox"/> Fibrocystic breasts	<input type="checkbox"/> Irritability	<input type="checkbox"/> Increased body/facial hair	<input type="checkbox"/> Headaches
<input type="checkbox"/> Thinning skin	<input type="checkbox"/> Uterine fibroids		<input type="checkbox"/> Bone loss

Category 2: Adrenal Hormone Imbalance

Mark which of the following symptoms are troublesome and/or persist over time.

<input type="checkbox"/> Aches and pains	<input type="checkbox"/> Elevated triglycerides	<input type="checkbox"/> Morning fatigue	<input type="checkbox"/> Bone loss
<input type="checkbox"/> Sleep disturbances	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Blood sugar imbalance
<input type="checkbox"/> Infertility	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Allergic conditions	<input type="checkbox"/> Autoimmune illness
<input type="checkbox"/> Chronic illness	<input type="checkbox"/> Evening fatigue	<input type="checkbox"/> Susceptibility to infections	

Category 3: Thyroid Hormone Imbalance

Mark which of the following symptoms are troublesome and/or persist over time.

<input type="checkbox"/> Aches and pains	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Brittle nails	<input type="checkbox"/> Depression
<input type="checkbox"/> Dry skin	<input type="checkbox"/> Cold hands and feet	<input type="checkbox"/> Headaches	<input type="checkbox"/> Infertility
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Foggy thinking	<input type="checkbox"/> Weight gain	<input type="checkbox"/> Feeling cold all the time
<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Low libido	<input type="checkbox"/> Inability to lose weight	<input type="checkbox"/> Sleep disturbances
<input type="checkbox"/> Constipation	<input type="checkbox"/> Thinning hair	<input type="checkbox"/> Menstrual irregularities	<input type="checkbox"/> Elevated cholesterol

Category 4: Cardiometabolic Risk

Mark which of the following symptoms are troublesome and/or persist over time.

<input type="checkbox"/> Smoker	<input type="checkbox"/> Weight gain	<input type="checkbox"/> Heart disease or family history of heart disease
<input type="checkbox"/> High blood sugar	<input type="checkbox"/> Sugar cravings	<input type="checkbox"/> Diabetes or family history of diabetes
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Waist size greater than 35 inches
<input type="checkbox"/> Overweight or obese	<input type="checkbox"/> Low physical activity	