LIVE WELL WITH PHARMASAVE®

With 3 convenient locations to serve you:
442 Main Street, **Wolfville**, 25 Main Street, **Hantsport**, 9816 Main Street, **Canning**

5 PAGE DOCUMENT

HORMONE EVALUATION

MEDICAL HISTORY:	

Date: _____Month _____Day _____Year

First Name: _____ **Last Name:** _____

Birth date: _____Month _____Day _____Year

Address: _____

City: _____ Prov._____ **Postal code:** _____

Phone:(Day): _____ (Evening): _____E-mail: _____

Gender: ___Male ___Female **Height:** _____ **Weight:** _____

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

Select the Pharmasave location you prefer: ___ Wolfville ___ Hantsport ___ Canning

Please mark answers with an X

How often and how much?
Do you use tobacco? ___Yes ___No _____
Do you use alcohol? ___Yes ___No _____
Do you use caffeine? ___Yes ___No _____

Allergies: Please check all that apply:

___ Penicillin	___ morphine	___ dye	___ pets
___ Codeine	___ aspirin	___ nitrates	___ seasonal (pollen)
___ sulpha	___ foods	___ no known allergies	

Other: _____

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

MEDICAL HISTORY:	Continued

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

___Heart disease (congestive heart failure)	___Hormonal related issues	___Headaches
___High cholesterol or lipids	___Lung condition (asthma,COPD)	___Eye disease
___High blood pressure	___Blood clotting problems	___Other
___Cancer	___Arthritis or joint problems	_____
___Ulcers (stomach, esophagus)	___Depression	_____
___Thyroid disease (Hyper or hypo)	___Epilepsy	_____

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)	_____

How many pregnancies have you had? ___ Number of children? ___
Have you had an interrupted pregnancy? ___ No ___ Yes
Have you had a hysterectomy? ___ No ___ Yes (date : _____)
Ovaries removed? ___ No ___ Yes
Have you had a tubal ligation? ___ No ___ Yes

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: _____

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, etc)

_____ _____
_____ _____
_____ _____
_____ _____

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:

_____ _____
_____ _____
_____ _____

Bone Size: ___ Small ___ Medium ___ Large
Body Type: ___ Androgenic ___ Estrogenic

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CURRENT PRESCRIPTION MEDICATIONS:	

Medication Name	Strength	How often per day	When started

Hormones Previously Taken:

Medication Name	Date started	Date stopped	Reason

Have you ever used oral contraceptives? ___Yes ___No
If Yes, did you experience any problems: ___Yes ___No
If Yes, please describe the problem: _____
_____ _____
_____ _____

Over the Counter Products

Please check all products that you use occasionally or regularly. Check all that apply.

___ Aspirin
___Acetaminophen
___Ibuprofen
___Cough suppressant
___Antihistamines
___ Decongestants
___Sleep aids
___Antidiarrheals
___Laxatives/stool softeners
___Diet aids
___Antacids
___Acid blockers
___Other (please list):

_____ _____
_____ ____
_____ _____

Nutritional/Natural Supplements: **Please identify and list the products you are using:**

___vitamins (multiple or single vitamins such as B complex, E, C, beta carotene)

___minerals (calcium, magnesium, chromium, colloidal minerals, single minerals)

___enzymes (digestive formulas, papaya, bromelain, Co-Enzyme Q10)

___nutrition/protein supplements (shark cartilage, protein powders, amino acids, fish oils
___others (glucosamine, garlic, etc.)

Products:

_____ _____
_____ _____
_____ _____

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

___ Doctor ___ Self ___ Friend/Family Member ___ Other

What are your goals with taking BHRT?

_____- _____
_____ _____
_____ _____
_____ _____
_____ _____

Please write down any questions you have about Bio-Identical Hormone Replacement Therapy.

_____
_____
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HORMONAL SYMPTOM CHART:	

	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				
Memory Loss				
Bladder Symptoms				
Arthritis				
Harder to reach climax				
Decreased sex drive				
Hair Loss				

SUBMIT FORM

For Pharmacy Use Only

Date Received:
Date Reviewed:
Action:

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