

LIVE WELL WITH

**PHARMASAVE**<sup>®</sup>

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

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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

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

- |   |   |                                      |
|---|---|--------------------------------------|
| <input type="checkbox"/> Heart disease (congestive heart failure) | <input type="checkbox"/> Hormonal related issues      | <input type="checkbox"/> Headaches   |
| <input type="checkbox"/> High cholesterol or lipids               | <input type="checkbox"/> Lung condition (asthma,COPD) | <input type="checkbox"/> Eye disease |
| <input type="checkbox"/> High blood pressure                      | <input type="checkbox"/> Blood clotting problems      | <input type="checkbox"/> Other       |
| <input type="checkbox"/> Cancer                                   | <input type="checkbox"/> Arthritis or joint problems  | _____                                |
| <input type="checkbox"/> Ulcers (stomach, esophagus)              | <input type="checkbox"/> Depression                   | _____                                |
| <input type="checkbox"/> Thyroid disease (Hyper or hypo)          | <input type="checkbox"/> Epilepsy                     | _____                                |

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

- |   |                  |       |
|---|------------------|-------|
| <input type="checkbox"/> Uterine Cancer     | Family member(s) | _____ |
| <input type="checkbox"/> Ovarian Cancer     | Family member(s) | _____ |
| <input type="checkbox"/> Fibrocystic Breast | Family member(s) | _____ |
| <input type="checkbox"/> 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

**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.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Aspirin           | <input type="checkbox"/> Decongestants             | <input type="checkbox"/> Antacids             |
| <input type="checkbox"/> Acetaminophen     | <input type="checkbox"/> Sleep aids                | <input type="checkbox"/> Acid blockers        |
| <input type="checkbox"/> Ibuprofen         | <input type="checkbox"/> Antidiarrheals            | <input type="checkbox"/> Other (please list): |
| <input type="checkbox"/> Cough suppressant | <input type="checkbox"/> Laxatives/stool softeners |   |
| <input type="checkbox"/> Antihistamines    | <input type="checkbox"/> Diet aids                 |   |

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

**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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**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				

For Pharmacy Use Only

Date Received:

Date Reviewed:

Action:

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