PPPreckshot
PROFESSIONAL PHARMACY

Hormone Consultation for Women

Patient Name ______ Today's Date ______

Birth Date ______ Phone ______

Address ______

City ______ State ______ Zip ______

E-mail ______

Marital Status ______ Weight ______

Occupation ______ Height ______

Allergies (Please check all that apply)

- ☐ Penicillin
- ☐ Codeine
- ☐ Sulfa Drugs
- ☐ Morphine
- ☐ Aspirin
- ☐ Food Allergies
- ☐ Dye Allergies
- ☐ Nitrate Allergy
- ☐ Pet Allergies
- ☐ Seasonal Allergies
- ☐ Food Allergy
- ☐ Dairy Allergy
- ☐ Other ______

If you selected other, what other allergies do you suffer from?

Please describe any allergic reactions you have experienced due to the selected fields above.

Physician Information: Please include Physician Name, Address & Phone

How did you arrive at the decision to consider bio-identical hormone replacement? (Check all that apply)

☐ Physician ☐ Self ☐ Friend/Family Member

☐ Other

Please indicate current prescription medications and nutritional supplements:
(Bring all medications and supplements with you to your scheduled consultation)

Name, Strength, How often, How many per day

Have you had any of the following tests performed in the past 2 years?

	Yes	No	Normal	Abnormal
Mammogram	○	○	○	○
Mammogram (Normal or Abnormal)	○	○	○	○
Pap Smear	○	○	○	○
Pap Smear (Normal or Abnormal)	○	○	○	○
Bone Density	○	○	○	○
Bone Density (Normal or Abnormal)	○	○	○	○

Bone Size (Check box)

- ◯ Small
- ◯ Medium
- ◯ Large

Have you ever used oral contraceptives?

- ◯ Yes
- ◯ No

If you have used oral contraceptives, did you have any problems using them?

- ☐ Yes
- ☐ No
- ☐ If yes, what were the problems? ____________________

Do you have, or have you ever had Premenstrual Syndrome (PMS)?

- ☐ Yes
- ☐ No
- ☐ If yes, please explain symptoms ____________________

When was your last cycle? ____________________

How many days did it last? ____________________

Since you first began having menses, have you ever had what YOU consider to be abnormal cycles?

- ☐ Yes
- ☐ No
- ☐ If yes, please explain ____________________

How many pregnancies have you had? ____________________

How many children? ____________________

Have you had any interrupted pregnancies?

- ◯ Yes
- ◯ No

Have you had a hysterectomy?

- ☐ Yes
- ☐ No
- ☐ Date ____________________

Have you had your ovaries removed?

- ◯ Yes
- ◯ No

Have you had a tubal litigation?

- ◯ Yes
- ◯ No

Medical Conditions / Diseases: Please check all that apply for you or an immediate family member.

Allergies/Asthma
- [ ] Self
- [ ] Family

Alzheimer's
- [ ] Self
- [ ] Family

Arthritis
- [ ] Self
- [ ] Family

Stroke
- [ ] Self
- [ ] Family

Eye Disease
- [ ] Self
- [ ] Family

Diabetes
- [ ] Self
- [ ] Family

Thyroid Disease
- [ ] Self
- [ ] Family

GERD
- [ ] Self
- [ ] Family

Anxiety Disorder
- [ ] Self
- [ ] Family

Clotting Disorder
- [ ] Self
- [ ] Family

Fibrocystic Breast
- [ ] Self
- [ ] Family

High Cholesterol or Lipids
- [ ] Self
- [ ] Family

Ulcers
- [ ] Self
- [ ] Family

Migraines / Headaches
- [ ] Self
- [ ] Family

Emphysema / COPD
- [ ] Self
- [ ] Family

Seizure Disorder
- [ ] Self
- [ ] Family

Heart Disease
- [ ] Self
- [ ] Family

Depression
- [ ] Self
- [ ] Family

Eczema
- [ ] Self
- [ ] Family

High Blood Pressure
- [ ] Self
- [ ] Family

Cancer
- [ ] Self
- [ ] Family

Osteoporosis
- [ ] Self
- [ ] Family

Fibromyalgia
- [ ] Self
- [ ] Family

Irritable Bowel
- [ ] Self
- [ ] Family

Please indicate your symptoms for the following conditions by using the following numeric scale: 1 being no symptoms at all to 5 being the worst symptoms imaginable.

	1	2	3	4	5
Arthritis, Painful Joints	◯	◯	◯	◯	◯
Hair Loss	◯	◯	◯	◯	◯
Fatigue, Loss of Energy	◯	◯	◯	◯	◯
Mood Swings, Irritable	◯	◯	◯	◯	◯
Night Sweats / Hot Flashes	◯	◯	◯	◯	◯
Osteoporosis	◯	◯	◯	◯	◯
Short Term Memory Loss	◯	◯	◯	◯	◯
Sleep Disorders, Insomnia	◯	◯	◯	◯	◯
Anxiety	◯	◯	◯	◯	◯
Breasts - Tender, Swollen	◯	◯	◯	◯	◯
Headaches, Migraines	◯	◯	◯	◯	◯
Increased Irritability, Temper	◯	◯	◯	◯	◯
Mood Swings	◯	◯	◯	◯	◯
Weight Gain, Increase in Waist Size	◯	◯	◯	◯	◯
Vaginal Dryness	◯	◯	◯	◯	◯
Depression	◯	◯	◯	◯	◯
Digestive Issues (Gas, Bloating, Heartburn, Indigestion)	◯	◯	◯	◯	◯
Fluid Retention	◯	◯	◯	◯	◯
Breakthrough Bleeding	◯	◯	◯	◯	◯
Memory Loss	◯	◯	◯	◯	◯
Difficulty Reaching Orgasm, Decreased Libido	◯	◯	◯	◯	◯
Dry Skin / Hair	◯	◯	◯	◯	◯
Heavy / Irregular Menses	◯	◯	◯	◯	◯
Sleep Disturbances / Insomnia	◯	◯	◯	◯	◯
Incontinence / Frequent Urination	◯	◯	◯	◯	◯

DIET: Read the following and circle the number that applies:
1 = Do not consume or use
2 = Consume or use 2 to 3 times monthly
3 = Consume or use weekly
4 = Consume or use daily

	1	2	3	4
Alcohol	◯	◯	◯	◯
Artificial Sweeteners	◯	◯	◯	◯
Candy, Desserts, Refined Sugar	◯	◯	◯	◯
Carbonated Beverages	◯	◯	◯	◯
Chewing Tobacco	◯	◯	◯	◯
Cigarettes	◯	◯	◯	◯
Cigars / Pipes	◯	◯	◯	◯
Caffeinated Beverages	◯	◯	◯	◯
Fast Foods	◯	◯	◯	◯
Fried Foods	◯	◯	◯	◯
Luncheon Meats	◯	◯	◯	◯
Margarine	◯	◯	◯	◯
Milk Products	◯	◯	◯	◯
Radiation Exposure (1 = No, 2 = Yes)	◯	◯	◯	◯
Refined Flour / Baked Goods	◯	◯	◯	◯
Vitamins and Minerals	◯	◯	◯	◯
Water, distilled	◯	◯	◯	◯
Water, tap	◯	◯	◯	◯
Water, well	◯	◯	◯	◯
Diet often for weight control	◯	◯	◯	◯

LIFESTYLE:

	1	2	3	4
Exercise per week (1=2 or more times a week, 2= 1 time a week, 3= 1 or 2 times a month, 4= never, less than once a month)	○	○	○	○
Changed jobs (1= over 12 months ago, 2= within last 12 months, 3= within last 6 months, 4= within last 2 months)	○	○	○	○
Divorced (1= never, over 2 years ago, 2= within last 2 years, 3= within last year, 4= within last 6 months)	○	○	○	○
Work over 60 hours/week (1=never, 2= occasionally, 3= usually, 4= always)	○	○	○	○

Have you previously taken any hormones? If so, please explain what you have taken and why you stopped.

What are your goals with taking BHRT?

Please indicate any specific questions you have about BHRT?

Are there any specific health concerns or issues you would like to discuss during your consultation?

I understand that my hormone consultation with Preckshot Professional Pharmacy is with a pharmacist who specializes in hormone therapy

- **Who will not diagnose or treat any medical condition,**
- **Who will not replace the advice of my primary care physician in any way,**
- **Who will work with my referring health care provider to alleviate my hormone related symptoms**
- **And, who will help me to decide what nutritional supplements, if any, would be safe and appropriate**

Name: (Please Print) ______________________

Signature ______________________

Date ______________________

Please fax or send this completed questionnaire to:
Phone: 309-679-2047 Fax: 309-679-2051
www.preckshot.com

Please bring any nutritional supplements, medications and lab reports with you at the time of your consultation.