

Natural Hormone Replacement  
**CONFIDENTIAL EVALUATION**

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.

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**GENERAL INFORMATION**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Cellular Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

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: \_\_\_\_\_

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**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: \_\_\_\_\_

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:** \_\_\_\_\_

\_\_\_\_\_

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## **PAST MEDICAL CONDITIONS**

Childhood diseases: \_\_\_\_\_

Heart Trouble \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Stroke \_\_\_\_\_ Varicose Veins \_\_\_\_\_

Clotting Defects \_\_\_\_\_ Diabetes \_\_\_\_\_ Kidney Trouble \_\_\_\_\_ Epilepsy \_\_\_\_\_ Fractures \_\_\_\_\_

Arthritis \_\_\_\_\_ Colitis \_\_\_\_\_ Gallbladder Trouble \_\_\_\_\_ Asthma \_\_\_\_\_ Chronic Fatigue \_\_\_\_\_

Fibromyalgia \_\_\_\_\_ Eating Disorder \_\_\_\_\_ Cancer \_\_\_\_\_

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## **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: \_\_\_\_\_

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## **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.:

Name: \_\_\_\_\_ Disease: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Disease: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Disease: \_\_\_\_\_ Age: \_\_\_\_\_

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

Name: \_\_\_\_\_ Disease: \_\_\_\_\_ Age at death: \_\_\_\_\_

Name: \_\_\_\_\_ Disease: \_\_\_\_\_ Age at death: \_\_\_\_\_

Name: \_\_\_\_\_ Disease: \_\_\_\_\_ Age at death: \_\_\_\_\_

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## **GYNECOLOGICAL HISTORY**

Age of first period: \_\_\_\_\_ Date of last period: \_\_\_\_\_

Date of last pelvic exam: \_\_\_\_\_ and Pap smear: \_\_\_\_\_ Results? \_\_\_\_\_

Have you had an endometrial ablation? \_\_\_\_\_ Date: \_\_\_\_\_ Results? \_\_\_\_\_

Have you ever had an abnormal pap? \_\_\_\_\_ Treatment: \_\_\_\_\_

Are you sexually active? \_\_\_\_\_ Are you trying to get pregnant? \_\_\_\_\_

Current birth control method: \_\_\_\_\_ How long: \_\_\_\_\_

Problem with it: \_\_\_\_\_ How long: \_\_\_\_\_

Past birth control and any related problems: \_\_\_\_\_

Do you have an IUD? \_\_\_\_\_

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 of 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? \_\_\_\_\_ When? \_\_\_\_\_

Have you had a hysterectomy? \_\_\_\_\_ When? \_\_\_\_\_

Do your ovaries remain? \_\_\_\_\_

## **CONSULTATION NOTES**

**(for pharmacist use)**

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