Central Iowa Compounding
3290 100th Street
Urbandale, Iowa 50322
Consultation Services
(Effective January 1, 2008)

1. Initial bioidentical hormone replacement consultation (having taken a class): Includes a total hormone work-up with review of patient's medical history, symptoms, current medications, vitamin/herb review, family risk factors, gynecological history, review of any labs provided to us such as hormones, thyroid, cholesterol, bone density, etc., and goals of hormone replacement. Patients will leave with a total "PLAN" individualized for them. Recommendations may be made for further testing. If prescriber referred, a copy of the evaluation along with a cover letter of explanation will be faxed to the prescriber with recommendations, which may include interpretations of lab tests. Patients will leave with a packet of information pertaining to their individual needs for further education including nutritional supplements. Patients are encouraged to bring any bottles of medications, vitamins, herbs, & etc. they may be taking. Average evaluation is 1& 1/2 to 2 hours, $75.00 per half-hour. If no class is taken the minimum is 2 to 3 hours with a "mini" class and charge is minimum $300.00. All initial consults include a 3-4 month follow-up call from the pharmacy to assess initial therapy.
2. Follow-up evaluation in person (usually between 3 months to 1 year after initial consultation depending on the patient's progress): Includes a review similar to initial evaluation with emphasis on symptom management, achievement of original goals, progress, and testing recommendations to ensure hormones are within a physiological range in the body. Adjustments may be made and recommendations faxed to the prescriber. Patient will receive and updated "Plan". Average evaluation is 30-60 minutes, $45.00 per half-hour.
3. Medication adjustments with review of any pertinent labs such as hormones in serum or saliva, cholesterol, thyroid, etc.: This includes a phone consultation to review symptoms and labs with the patient. A letter of recommendation is then faxed to the prescriber. No official "PLAN" is written up. Average time is 20-30 minutes, $45.00 per review.

Note: No appointment will be made until evaluation or re-check forms are filled out and returned to the pharmacy.

Please contact Lisa for any questions: 252-7688 or 1-888-799-5588

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.

GENERAL INFORMATION Date: ____________

Name: ______________________ Age: ________ Birth Date: ________

Street Address: ______________________ Apt. ________

City: ______________________ State: ________ Zip: ________

Occupation: ______________ ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Unemployed ☐ Other

Phone Day: ______________ Evening: ______________

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

Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

How did you hear about Natural Hormone Replacement Therapy: ☐ Ad ☐ Another Patient ☐ Friend ☐ Physician/Healthcare practitioner ☐ Books/Articles ☐ Class/Seminar ☐ Other

If you had a referral, who referred you? ______________

Have you discussed HRT with your Health Care Practitioner? ______________

Do you understand what Natural Hormone Replacement is? ______________

What are your three main symptoms/Concerns? 1. ______________ Since When? ________
2. ______________ ________
3. ______________ ________

MEDICAL STATUS

Primary Health Care Practitioner/Physician: ______________ Phone: ________

Address: ______________________ Fax: ________

Other Physicians Currently Seeing: ______________

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Height: ________ Weight: ________

Allergies: ______________________ Blood Type: ________

Current Diagnosis or Medical Conditions: ______________________________

____

Current Medications: ______________________________

____

____

Current Vitamins or OTC products: (Please list ALL, May bring in products at time of evaluation.) ______________________________

____

____

Current Herbs/etc.: ______________________________

Are you currently on Natural Progesterone cream? ☐Y☐ N If yes, brand name: ______________________________

How long have you been on Progesterone cream: __________ How much are you using and when: __________

Current Hormone Replacement Therapy: Name ______________________________ Strength: __________

Date started: ______________________________

How and when do you take current HRT? ______________________________

Previous Hormone Replacement Therapy:Name ______________________________ Strength: __________

Reason For Change: ______________________________

Any lab results you may wish to enclose would be helpful for your evaluation.

Exam/Lab Results:

	DATE	SERUM Blood	SALIVA	RESULTS
FSH				
PROGESTERONE				
ESTRIOL (E3)				
ESTRADIOL (E2)				
ESTRONE (E1)				
TESTOSTERONE:				
TOTAL				
FREE				
DHEA SULFATE				
CHOLESTEROL:				
T RIGLYCERIDES				
TOTAL				
HDL				
LDL				

Bone Density: ☐ Y ☐ N Date:________ Type: ☐ Back ☐ Hip T-Score:______________________

Have you ever had a mammogram: ☐ Y ☐ N Date: ________ Results: ______________________

Have you ever had your Thyroid tested: ☐ Y ☐ N Date: ______ TSH: ____ T4: _____ Free T3: ____ Other: _____

CURRENT AND PAST MEDICAL CONDITIONS:

Please check the ones that apply to you

	Y	N	Date of Diagnosis		Y	N	Date
Heart Disease				High Blood Pressure			
Stroke				Varicose Veins			
Clotting Defects				Diabetes			
Kidney Trouble				Epilepsy			
Fractures				Arthritis			
Colitis				Gallbladder trouble			
Irritable Bowel				Asthma			
Ulcers				Autoimmune Disorder			
Fibromyalgia				Osteoporosis			
Chronic Fatigue				Cancer			
Eating Disorder							

HABITS:

Dietary Restrictions:____

Meal Choices: Breakfast:______________________________________
Lunch:______________________________________
Dinner:______________________________________

Do you get routine exercise:_____ What type:______________________ How often: ______________

Do you use tobacco products: ☐ Y ☐ N How Much: __________ How Long:______________

Do you use alcohol products: ☐ Y ☐ N How Much: __________ How Long:______________

Do you use caffeine products: ☐ Y ☐ N How Much: __________ How Long:______________

FAMILY HISTORY:

LIVING	IMPORTANT DISEASES	LIVING	DECEASED
Mother			
Father			
Brothers			
Sisters			
Aunts			
Uncles			
Paternal Grandma			
Paternal Grandpa			
Maternal Grandma			
Maternal Grandpa			

GYNECOLOGICAL HISTORY

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

Date of last pelvic exam: ________ and Pap smear: ________ Results: ______________

Have you ever had an abnormal pap? ☐Y☐ N When? ________ How many times? ________

Treatment: ______________________________

Are you sexually active? ☐Y ☐ N Are you trying to get pregnant? ☐Y☐ N

Current birth control method: ______________________ How Long: ________

Problem with it: ______________________ How Long: ________

Past birth control and related problems: ______________________

Have you ever been on birth control? ☐Y ☐ N Brand: ____________ How long on? ________

Side Effects? ______________________________

PLEASE FILL OUT NEXT SECTION EVEN IF NOT CYCLING NOW

How many days from start of one period to the start of next: ______________________

Number of days of flow: ____________ Amount of bleeding: ______________________

Amount of cramping: ______________________________

Premenstrual symptoms: ______________________________

Starting and ending when? ______________________________

Any current changes in your normal cycle: ______________________________

PLEASE FILL OUT THIS SECTION EVEN IF NOT CYCLING NOW

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 ☐Y☐ N Abortions ☐Y☐ N

Which pregnancy? ____________________ How far along? ____________________

____

Have you had a tubal ligation? ☐Y ☐ N When? ________ Cycle or symptoms change after? ________

____

Have you had a hysterectomy? ☐Y☐ N When? ________ Why? ____________________

____

Symptoms change after hysterectomy? ____________________

____

Have you had any part or whole ovary removed? ☐ Y☐ N When? ________ Why? ____________

____

Symptoms change after? ____________________

Age mother in menopause? ____________________

SYMPTOMS LIST

Each Category is divided into hormone deficiency and excess, as each has a different subset of symptoms. **Score the symptoms which apply to you 0(none), 1 (mild), 2 (Moderate) or 3 (severe).**

Estrogens (Estradiol)

Estrogen Deficiency

_____ Hot Flashes
_____ Night Sweats
_____ Vaginal Dryness
_____ Foggy Thinking
_____ Memory Lapses
_____ Incontinence
_____ Tearful
_____ Bone Loss
_____ Heart Palpitations
_____ Dry Skin/Hair
_____ Headaches
_____ Sleep Disturbances
_____ Depressed

Estrogen Excess

_____ Mood Swings(PMS)
_____ Tender Breast
_____ Water Retention
_____ Nervous
_____ Irritable
_____ Anxious
_____ Fibrocystic Breast
_____ Uterine Fibroids
_____ Weight Gain in Hips
_____ Weight Gain in Waist
_____ Sleep Disturbances
_____ Elevated Triglycerides
_____ Cystic Ovaries
_____ Breast Cancer
_____ Low Libido
_____ Headaches
_____ Bleeding Changes
_____ Sugar Cravings
_____ Cold Body Temperature

Progesterone

Progesterone Deficiency

_____ Hot Flashes
_____ Night Sweats
_____ Vaginal Dryness
_____ Foggy Thinking
_____ Memory Lapses
_____ Incontinence
_____ Tearful
_____ Depressed
_____ Sleep Disturbances
_____ Cramps
_____ PMS/Mood Swings
_____ Irregular Bleeding
_____ Break Thru Bleeding
_____ Heavy Periods
_____ Irritability
_____ Water Retention
_____ Headaches
_____ Anxiety
_____ Nervous
_____ Cystic Ovaries
_____ Heart Palpitations
_____ Bone Loss

Progesterone Excess

_____ Sleeplessness
_____ Breast Tenderness on Sides
_____ Decreased Libido
_____ Mild Depression
_____ Candida Infections

Androgens (DHEA and Testosterone)

Androgen Deficiency

_____ Low Libido
_____ Vaginal Dryness
_____ Foggy Thinking
_____ Fatigue
_____ Aches and Pains
_____ Memory Lapses
_____ Incontinence
_____ Depressed
_____ Bone Loss
_____ Decreased Muscle Mass
_____ Thinning Skin
_____ Heart Palpitations
_____ Headaches
_____ Fibromyalgia
_____ Sleep Disturbances

Androgen Excess

_____ Increased Facial hair
_____ Increased Body Hair
_____ Loss of Scalp Hair
_____ Increased Acne
_____ Oily Skin
_____ Irritable
_____ Anxious
_____ Ovarian Cyst

Cortisol (Adrenal Function)

Cortisol Deficiency

_____ Fatigue
_____ Sugar Craving
_____ Allergies
_____ Chemical Sensitivity
_____ Stress
_____ Cold Body Temp
_____ Heart Palpitations
_____ Aches and Pains
_____ Irritable
_____ Arthritis

Cortisol Excess

_____ Sleep Disturbances
_____ Bone Loss
_____ Fatigue
_____ Weight Gain in Waist
_____ Thinning Skin
_____ Loss of Muscle Mass
_____ Elevated Triglycerides
_____ Irritable
_____ Anxious
_____ Memory Lapses
_____ Depressed
_____ Headaches
_____ Stress
_____ Sugar Cravings
_____ Hair Loss
_____ Low Libido
_____ Increased Facial Hair
_____ Increased Body hair
_____ Acne
_____ Nervous

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Thyroid

Thyroid Deficiency		Thyroid Excess
______ Tired/Exhausted	______ Hair Loss	______ Rapid Weight Loss
______ Sad or Depressed	______ Hair Dry or Brittle	______ Insomnia
______ Cold Body Temp	______ Nails Breaking or Brittle	______ Difficulty Falling Asleep
______ Cold hands & Feet	______ Aches and Pains	______ Unusual Sweating
______ Weight Gain	______ Low Libido	______ Always Feeling Hot
______ Can't Lose Weight	______ Heart Palpitations	______ Bulging Eyes
______ Memory Lapses	______ Sleep Disturbances	______ Erratic Behavior
______ Forgetful	______ Swelling/Puffy Eyes/Face	______ Anxiety
______ High Cholesterol	______ Bone Loss	______ Irritability
______ Foggy thinking	______ Decreased Muscle Mass	______ Nervous
______ Mood Changes	______ Thinning Skin	______ Panic Attacks
______ Low Blood Pressure	______ Infertility Problems	______ Decreased Concentration
______ Slow Pulse Rate	______ Slowed Reflexes	______ Short Attention Span
______ Decreased Sweating	______ Constipation	______ Rapid Heart Beat
______ Slow Ankle reflex	______ Hoarseness	______ Goiter

IGF-1 Testing for Human Growth Hormone Levels

IGF-1 Deficiency		IGF-1 Excess
______ Rapid Aging	______ Osteoporosis	______ Visual Field Defects
______ Sleep Disturbances	______ Thinning Skin	______ Thickening of Palms
______ Memory Impairment	______ Insulin Insensitivity	______ Thickening of Heel Pads
______ Decreased Stamina	______ Slowing Cognition	______ Increased Cranial Growth
______ Decreased Libido	______ Sexual Dysfunction	______ Changes in Skull/Face
______ Increased Fatigue	______ Central Obesity	______ Enlarged/Thickening Heart
______ Heart Disease		

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Do you wish for us to fill out the necessary paper work to seek reimbursement for this evaluation through your insurance provider? YES: NO:

If Yes, list your insurance provider:

If you have a prescription filled at Central Iowa Compounding do you wish for us to fill out the paper work necessary to seek reimburseme YES: _________ NO: _________

If yes, list your **prescription** insurance Prov (Please note that sometimes your prescription provider is different than your medical provider)

CONSULTATION NOTES:

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