

# **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. \_\_\_\_\_

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## **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				

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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							

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

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**FAMILY HISTORY:**

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

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**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? \_\_\_\_\_

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***PLEASE FILL OUT NEXT SECTION EVEN IF NOT CYCLING NOW***

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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: \_\_\_\_\_

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*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

**Progesterone Excess**

- Heart Palpitations
- Bone Loss

- 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

Thyroid

**Thyroid Deficiency**

- |   |  |
|---|--|
| <input type="checkbox"/> Tired/Exhausted    | <input type="checkbox"/> Hair Loss                 |
| <input type="checkbox"/> Sad or Depressed   | <input type="checkbox"/> Hair Dry or Brittle       |
| <input type="checkbox"/> Cold Body Temp     | <input type="checkbox"/> Nails Breaking or Brittle |
| <input type="checkbox"/> Cold hands & Feet  | <input type="checkbox"/> Aches and Pains           |
| <input type="checkbox"/> Weight Gain        | <input type="checkbox"/> Low Libido                |
| <input type="checkbox"/> Can't Lose Weight  | <input type="checkbox"/> Heart Palpitations        |
| <input type="checkbox"/> Memory Lapses      | <input type="checkbox"/> Sleep Disturbances        |
| <input type="checkbox"/> Forgetful          | <input type="checkbox"/> Swelling/Puffy Eyes/Face  |
| <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Bone Loss                 |
| <input type="checkbox"/> Foggy thinking     | <input type="checkbox"/> Decreased Muscle Mass     |
| <input type="checkbox"/> Mood Changes       | <input type="checkbox"/> Thinning Skin             |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Infertility Problems      |
| <input type="checkbox"/> Slow Pulse Rate    | <input type="checkbox"/> Slowed Reflexes           |
| <input type="checkbox"/> Decreased Sweating | <input type="checkbox"/> Constipation              |
| <input type="checkbox"/> Slow Ankle reflex  | <input type="checkbox"/> Hoarseness                |

**Thyroid Excess**

- Rapid Weight Loss
- Insomnia
- Difficulty Falling Asleep
- Unusual Sweating
- Always Feeling Hot
- Bulging Eyes
- Erratic Behavior
- Anxiety
- Irritability
- Nervous
- Panic Attacks
- Decreased Concentration
- Short Attention Span
- Rapid Heart Beat
- Goiter

IGF-1 Testing for Human Growth Hormone Levels

**IGF-1 Deficiency**

- |   |  |
|---|--|
| <input type="checkbox"/> Rapid Aging        | <input type="checkbox"/> Osteoporosis          |
| <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> Thinning Skin         |
| <input type="checkbox"/> Memory Impairment  | <input type="checkbox"/> Insulin Insensitivity |
| <input type="checkbox"/> Decreased Stamina  | <input type="checkbox"/> Slowing Cognition     |
| <input type="checkbox"/> Decreased Libido   | <input type="checkbox"/> Sexual Dysfunction    |
| <input type="checkbox"/> Increased Fatigue  | <input type="checkbox"/> Central Obesity       |
| <input type="checkbox"/> Heart Disease      |  |

**IGF-1 Excess**

- Visual Field Defects
- Thickening of Palms
- Thickening of Heel Pads
- Increased Cranial Growth
- Changes in Skull/Face
- Enlarged/Thickening Heart