



644 Old Northern Road, Dural NSW 2158
Tel 1300 725 868 Fax 1300 726 858
Email info@customcarepharmacy.com.au

Confidential Hormone Evaluation Questionnaire

Today's Date: _____
Name: _____ **Birthdate:** _____ **Age:** _____
Address: _____
Suburb: _____ **State:** _____ **Postcode:** _____
Phone: _____ **E-Mail Address:** _____
Gender: Male Female **Height:** _____ **Weight:** _____

How did you hear about Biologically Identical Hormone Replacement and CustomCare Pharmacy?

- Advertisement
- Books/Articles
- Another Patient
- Internet
- Physician/Healthcare Provider
- Other (please specify) _____

Do you understand what Bio-Identical Hormone Replacement is?

Do you understand the risks involved due to your use of Bio-Identical Hormone Replacement? *

**It is recommended that you consult with your physician regarding these risks.*

What are your goals for Bio-Identical Hormone Replacement?

Medical History

Do you use tobacco? Yes No How often and how much? _____
Do you use alcohol? Yes No _____
Do you use caffeine? Yes No _____

Doctor's Name: _____ **Address:** _____ **Phone:** _____

Allergies: Please check all that apply.

___ penicillin ___ morphine ___ dye allergies ___ pet allergies
___ codeine ___ aspirin ___ nitrate allergy ___ sulfa drug
___ food allergies ___ seasonal (pollen) allergies ___ no known allergies
other: _____

Please describe the allergic reaction you experienced and when it occurred?

Over-the-counter (OTC) issues:

Please check all products that you use occasionally or regularly. Check all that apply.

___ Pain reliever ___ Combination product (cough+cold reliever)(eg: Codral Cough, Cold & Flu)
___ Aspirin ___ Sleep aids (eg: Restavit, Unisom, Dozile)
___ Paracetamol (eg: Panadol) ___ Antidiarrheals (eg: Imodium, Lomotil, Kaomagna)
___ Ibuprofen (eg: Nurofen) ___ Laxatives/Stool softeners (eg: Coloxy with senna, Durolax)
___ Naproxen (eg: Naprogesic) ___ Diet aids/weight loss products (eg: Fat Blaster)
___ Ketoprofen (eg: Orudis) ___ Antacids (eg: Mylanta)
___ Cough suppressant (eg: Durotuss) ___ Acid blockers (eg: Zantac, Pepcid)
___ Antihistamine product (eg: Telfast, Claratyne, Zyrtec, Phenergan, Polaramine)
___ Decongestant product (eg: Sudafed) ___ Other (please list) _____

___ **Nutritional/Natural Supplements: Please identify and list the products you are using:**

Vitamins (eg: multiple or single vitamins such as B complex, E, C, beta carotene)
 Minerals (eg: calcium, magnesium, chromium, colloidal minerals, various single minerals)
 Herbs (eg: Ginseng, Ginkgo Biloba, Echinacea, other herbal medicinal teas, tinctures, remedies, etc.)
 Enzymes (eg: digestive formulas, papaya, bromelain, CoEnzyme Q10, etc.)
 Nutrition/ protein supplements (eg: shark cartilage, protein powers, amino acids, fish oil, etc.)
 Others (glucosamine, etc.)

Medical Conditions/Diseases: Please check all that apply to you.

- | | |
|--|---|
| <input type="checkbox"/> Heart disease (eg: Congestive Heart Failure) | <input type="checkbox"/> Blood Clotting Problems |
| <input type="checkbox"/> High cholesterol or lipids (eg: Hyperlipidemia) | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High blood pressure (eg: Hypertension) | <input type="checkbox"/> Arthritis or joint problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Ulcers (stomach, esophagus) | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Headaches/migraines |
| <input type="checkbox"/> Hormonal Related Issues | <input type="checkbox"/> Eye Disease (glaucoma, etc.) |
| <input type="checkbox"/> Lung condition (eg: asthma, emphysema, COPD) | <input type="checkbox"/> Other: Please list: _____ |
-
-

Current Prescription Medications:

Medication Name	Strength	Date Started	How often per day.

List Hormones previously taken.	Date Started	Date Stopped	Reason

Bone Size _____ Small _____ Medium _____ Large _____

How did you arrive at the decision to consider Bio-Identical Hormone Replacement Therapy?

- Doctor Self Friend/Family Member Other

HORMONE REPLACEMENT THERAPY PATIENT INFORMATION SHEET

To what degree do you experience the following?

	ABSENT	MILD	MODERATE	SEVERE
Fatigue or loss of energy	_____	_____	_____	_____
Depression, low or negative	_____	_____	_____	_____
Irritability, anger or bad temper	_____	_____	_____	_____
Anxiety or nervousness	_____	_____	_____	_____
Lack of motivation	_____	_____	_____	_____
Loss of memory or concentration	_____	_____	_____	_____
Impotence	_____	_____	_____	_____
Inability to ejaculate	_____	_____	_____	_____
Dry skin on face or hands	_____	_____	_____	_____
Weight gain	_____	_____	_____	_____
Backache, joint pain or stiffness	_____	_____	_____	_____
Loss of muscle mass/tone	_____	_____	_____	_____

Waiver

I hereby release CustomCare Compounding Pharmacy employees and pharmacists from any and all liability whatsoever associated with or connected to my Bio-Identical Hormone Replacement Therapy (BHRT) consultation and/or use of BHRT. I acknowledge that I am legally responsible for and aware of the potential side effects associated with BHRT. I understand that no doctor, nurse, pharmacist, or administrative personnel can guarantee that BHRT will provide the results I seek. I am participating in this program by my own choice, and assume all responsibility for my use of BHRT.

I fully understand that it is my responsibility to have an annual physical examination along with appropriate laboratory testing. I am currently under the medical supervision of a primary care physician. I have been advised in this hormone questionnaire about the increased risks associated with the use of BHRT. I have answered truthfully all of the questions on this questionnaire.

Signed _____

Date _____