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 such as myocardial infarction, heart disease, stroke, breast cancer? *

_____
_____

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

What are your goals for Bio-Identical Hormone Replacement?

_____

_____

Medical History

			How often and how much?
Do you use tobacco?	☐Yes	☐No	_____
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
__ Aspirin
__ Paracetamol (eg: Panadol)
__ Ibuprofen (eg: Nurofen)
__ Naproxen (eg: Naprogesic)
__ Ketoprofen (eg: Orudis)
__ Cough suppressant (eg: Durotuss)
__ Antihistamine product (eg: Telfast, Claratyne, Zyrtec, Phenergan, Polaramine)
__ Decongestant product (eg: Sudafed)
__ Combination product (cough+cold reliever)(eg: Codral Cough, Cold & Flu)
__ Sleep aids (eg. Restavit, Unisom, Dozile)
__ Antidiarrheals (eg: Imodium, Lomotil, Kaomagna)
__ Laxatives/Stool softeners (eg: Coloxy with senna, Durolax)
__ Diet aids/weight loss products (eg: Fat Blaster)
__ Antacids (eg: Mylanta)
__ Acid blockers (eg. Zantac, Pepcid)
__ 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.

___	Heart disease (eg: Congestive Heart Failure)	___	Blood Clotting Problems
___	High cholesterol or lipids (eg: Hyperlipidemia)	___	Diabetes
___	High blood pressure (eg: Hypertension)	___	Arthritis or joint problems
___	Cancer	___	Depression
___	Ulcers (stomach, esophagus)	___	Epilepsy
___	Thyroid disease	___	Headaches/migraines
___	Hormonal Related Issues	___	Eye Disease (glaucoma, etc.)
___	Lung condition (eg: asthma, emphysema, COPD)	___	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 _____

Body Type: ☐Androgenic ☐Estrogenic

Have you ever used oral contraceptives? ☐No ☐Yes
Any problems? ☐No ☐Yes
If YES, describe any problem(s).

_____
_____

Patient Name: _____

How many pregnancies have you had ? ___ How many children?_____

Any interrupted pregnancies? ☐No ☐Yes

Have you had a hysterectomy? ☐No ☐Yes (Date of Surgery) _____
Ovaries removed? ☐No ☐Yes

Have you had a tubal ligation? ☐No ☐Yes (Date) _____

Do you have a family history of any of the following?

Uterine Cancer	_____	Family member(s)	_____
Ovarian Cancer	_____	Family member(s)	_____
Fibercystic breast	_____	Family member(s)	_____
Breast cancer	_____	Family member(s)	_____
Heart Disease	_____	Family member(s)	_____
Osteoporosis	_____	Family member(s)	_____

_____

Have you had any of the following tests performed? Check those that apply and note date of last test.

Mammography	☐No	☐Yes	Date: _____
PAP Smear	☐No	☐Yes	Date: _____

Since you first began having periods, have you ever had what YOU would consider to be abnormal cycles? ☐No ☐Yes Date: _____

If YES, please explain (such as age when this occurred, symptoms….):

_____
_____
_____
_____
_____

When was your last period? _____

How many days did it last? _____

Do you have, or did you ever have Premenstrual Syndrome(PMS)? ☐No ☐Yes
If YES, explain symptoms:

_____
_____
_____

PATIENT NAME: _____

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

☐Doctor ☐Self ☐Friend/Family Member ☐Other

What are your goals with taking BHRT?

_____
_____
_____
_____

Please write down any questions you have about Bio-Identical Hormone Replacement Therapy.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient Name: _____

HORMONE REPLACEMENT THERAPY PATIENT INFORMATION SHEET

	ABSENT	MILD	MODERATE	SEVERE
Fibrocystic Breast	_____	_____	_____	_____
Weight Gain	_____	_____	_____	_____
Heavy/Irregular menses	_____	_____	_____	_____
Hot Flashes	_____	_____	_____	_____
Dry Skin/Hair	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Night Sweats	_____	_____	_____	_____
Vaginal Dryness	_____	_____	_____	_____
Headaches	_____	_____	_____	_____
Irritability	_____	_____	_____	_____
Mood Swings	_____	_____	_____	_____
Breast Tenderness	_____	_____	_____	_____
Sleep Disturbances/Insomnia	_____	_____	_____	_____
Cramps	_____	_____	_____	_____
Fluid Retention	_____	_____	_____	_____
Breakthrough Bleeding	_____	_____	_____	_____
Fatigue	_____	_____	_____	_____
Loss of Memory	_____	_____	_____	_____
Bladder Symptoms	_____	_____	_____	_____

Arthritis	_____	_____	_____	_____
Harder to Reach Climax	_____	_____	_____	_____
Decreased Sex Drive	_____	_____	_____	_____
Hair Loss	_____	_____	_____	_____

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 of heart disease, myocardial infarction, stroke, and breast cancer possibly associated with the use of BHRT. I have answered truthfully all of the questions on this questionnaire.

Signed_____

Date _____