

CUSTOMCARE
Compounding Pharmacy



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

Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	How often and how much?
Do you use alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Do you use caffeine?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.

<input type="checkbox"/> Pain reliever	<input type="checkbox"/> Combination product (cough+cold reliever)(eg: Codral Cough, Cold & Flu)
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Sleep aids (eg. Restavit, Unisom, Dozile)
<input type="checkbox"/> Paracetamol (eg: Panadol)	<input type="checkbox"/> Antidiarrheals (eg: Imodium, Lomotil, Kaomagna)
<input type="checkbox"/> Ibuprofen (eg: Nurofen)	<input type="checkbox"/> Laxatives/Stool softeners (eg: Coloxy with senna, Durolax)
<input type="checkbox"/> Naproxen (eg: Naprogesic)	<input type="checkbox"/> Diet aids/weight loss products (eg: Fat Blaster)
<input type="checkbox"/> Ketoprofen (eg: Orudis)	<input type="checkbox"/> Antacids (eg: Mylanta)
<input type="checkbox"/> Cough suppressant (eg: Durotuss)	<input type="checkbox"/> Acid blockers (eg. Zantac, Pepcid)
<input type="checkbox"/> Antihistamine product (eg: Telfast, Claratyne, Zyrtec, Phenergan, Polaramine)	
<input type="checkbox"/> Decongestant product (eg: Sudafed)	<input type="checkbox"/> 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 powders, 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"/> High cholesterol or lipids (eg: Hyperlipidemia)
<input type="checkbox"/> High blood pressure (eg: Hypertension)
<input type="checkbox"/> Cancer
<input type="checkbox"/> Ulcers (stomach, esophagus)
<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Hormonal Related Issues
<input type="checkbox"/> Lung condition (eg: asthma, emphysema, COPD) | <input type="checkbox"/> Blood Clotting Problems
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Arthritis or joint problems
<input type="checkbox"/> Depression
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Headaches/migraines
<input type="checkbox"/> Eye Disease (glaucoma, etc.)
<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 _____

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	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date: _____
PAP Smear	<input type="checkbox"/> No	<input type="checkbox"/> 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: _____

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 _____