CUSTOMCARE
Compounding Pharmacy

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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?

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

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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)
__ 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)
__ 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.

___	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: ______________

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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

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

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Patient Name: ____

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 _______________