



Pharmacists: Tracy Dryer & Jill Caracci
19321 E. US 40 Hwy, Suite P
Independence, MO 64055
816-788-7928
Fax: 855-482-1010
BHRT@sterlingrx.net

Date _____

Female Information and Health Summary

Name _____ Date of Birth _____

Address _____ City/State/ZIP _____

Home Phone (____)-____-____ Cell (____)-____-____ Fax (____)-____-____

Email address _____ Who referred you to us? _____

Please List Your Healthcare Providers & Indicate Which Doctor to Contact Regarding Hormone Therapy

Name _____

Name _____

Specialty _____

Specialty _____

Address _____

Address _____

Phone _____

Phone _____

Fax _____

Fax _____

Any Known Medication Allergies? _____

Please List Any Medications You Are **Currently** Taking, Including Vitamins, Natural Supplements, or Non-Prescription Medications (**Doses of any hormones you are taking are necessary, because that is the current baseline to make a recommendation to your doctor:**)

Is your **Diet:** 1 Bad 2 Fair 3 Good 4 Very Good (please circle)

Exercise: type of activity, how frequent, and for how long? _____

Employer and Job Title _____

Circle your perceived stress level: 1 None 2 Mild 3 Moderate 4 Severe 5 Extremely Severe

Family History

Please check all that apply:

<input type="checkbox"/> Cancer (type)		
<input type="checkbox"/> Breast _____	Relationship to you _____	
<input type="checkbox"/> Uterine _____	Relationship to you _____	
<input type="checkbox"/> Ovarian _____	Relationship to you _____	
<input type="checkbox"/> Other _____	Relationship to you _____	
<input type="checkbox"/> Diabetes; type _____	Relationship to you _____	
<input type="checkbox"/> Heart Disease _____	Relationship to you _____	
<input type="checkbox"/> Osteoporosis _____	Relationship to you _____	
<input type="checkbox"/> Alzheimer's Disease _____	Relationship to you _____	
<input type="checkbox"/> Thyroid Disease _____	Relationship to you _____	

Past or Present Medical Conditions

Please check all that apply:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Fractures _____
<input type="checkbox"/> Cancer (type: _____)	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Depression	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Liver Disorder
<input type="checkbox"/> Diabetes (type: _____)	<input type="checkbox"/> Kidney Disorder	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Heart Condition _____	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Chronic Fatigue Syndrome
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Clotting Disorder	<input type="checkbox"/> Other _____
<input type="checkbox"/> Osteoporosis/Osteopenia	<input type="checkbox"/> Gallbladder Disease	

Gynecological History

- Have you had a hysterectomy? Yes No
If Yes, when? _____
- Have your ovaries been removed? Yes No
If Yes, when? _____
- Have you ever had a tubal ligation? Yes No
If Yes, when? _____
- Have you ever had an abnormal pap? Yes No
If Yes, when? _____
- Do you perform self-breast exams? Yes No
How often? _____

Obstetrical History

- Are you sexually active? Yes No
- Are you trying to get pregnant? Yes No
- Current method of birth control? _____ How long? _____
- Past method of birth control &/or any problems? _____
- Have you ever had children? Yes No
- Number of Pregnancies _____ Deliveries _____ Multiple Births _____

Have you ever had . . . (check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Sexual Problems | <input type="checkbox"/> Cervical Cancer | <input type="checkbox"/> Lack of Sex Drive |
| <input type="checkbox"/> Cervical Dysplasia | <input type="checkbox"/> Painful Intercourse | <input type="checkbox"/> Ovarian Cysts |
| <input type="checkbox"/> Vaginal Dryness | <input type="checkbox"/> Uterine fibroids | <input type="checkbox"/> Breast fibroids |
| <input type="checkbox"/> Vaginal Infections | <input type="checkbox"/> Lack of Energy | <input type="checkbox"/> HPV(vaginal warts) |
| <input type="checkbox"/> Pelvic Infections | <input type="checkbox"/> HSV (vaginal herpes) | <input type="checkbox"/> Inability to reach climax |
| <input type="checkbox"/> Increased facial &/or body hair growth | | |

Menstrual History

Present state of Menstruation

- | | | |
|----------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Regular | <input type="checkbox"/> Irregular | <input type="checkbox"/> Sporadic |
| <input type="checkbox"/> Light | <input type="checkbox"/> Heavy | <input type="checkbox"/> No Periods |

Have you missed periods altogether? Yes No

When was your last period? _____ How long is your cycle? _____

Do you have bleeding between periods? Yes No

Have you ever taken hormones before? Yes No

If so, please list **previous and current hormones taken, **doses**, and any side effects here:

Have you tried alternative therapies or taken any herbal or homeopathic products?

How did you become interested in bio-identical hormones?

Please check ALL symptoms below that apply (this is very important to the evaluation process)

Symptoms of low Progesterone?

- | | |
|---|---|
| <input type="checkbox"/> Swollen Breasts | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Anxiety/Irritability | <input type="checkbox"/> _____ per week |
| <input type="checkbox"/> Irregular menses | <input type="checkbox"/> Cramping |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Low Sex Drive |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Depression |
| <input type="checkbox"/> PMS | <input type="checkbox"/> Fuzzy Thinking |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Low Energy |
| <input type="checkbox"/> Food Cravings | |

Symptoms of low Estrogen?

- | | |
|--|--|
| <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> _____ per week |
| <input type="checkbox"/> Foggy Thinking | <input type="checkbox"/> Heart Palpitations |
| <input type="checkbox"/> Painful Intercourse | <input type="checkbox"/> Low Sex Drive |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Vaginal Dryness/Atrophy |
| <input type="checkbox"/> _____ per week | <input type="checkbox"/> Memory Lapses |
| <input type="checkbox"/> Yeast Infections | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Bone Loss | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> _____ per week |

Symptoms of low Testosterone?

- | | | |
|---|---|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Urinary Incontinence | <input type="checkbox"/> Low Energy |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Low Sex Drive | <input type="checkbox"/> Bone Loss |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Memory Lapses | <input type="checkbox"/> Muscle Weakness |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Vaginal Dryness | <input type="checkbox"/> Thinning Skin/Scalp Hair |

Other Symptoms _____

Top 3 symptoms you'd like resolved _____

Circle the number that best describes the DEGREE of symptom intensity you have experienced over the past month(s)

	None 0	Mild 1	Moderate 2	Severe 3
1. Hot flashes, perspiration, and/or chilly sensations?	0	1	2	3
2. Insomnia or restless, fragmented sleep?	0	1	2	3
3. Irritability, feeling anxious or apprehensive?	0	1	2	3
4. Feeling of depression and unhappiness and/or being miserable without obvious reason?	0	1	2	3
5. Sensations of dizziness or swimming in the head?	0	1	2	3
6. Feeling of weariness of mind and body with desire for rest; disinclination to make further efforts?	0	1	2	3
7. Pain of any kind affecting joints or muscles?	0	1	2	3
8. Headaches of any kind (tension, migraine, etc)?	0	1	2	3
9. Quickening or acceleration of heartbeat or fluttering/pounding heartbeat in a sitting or resting position?	0	1	2	3
10. Thinning or loss of scalp hair?	0	1	2	3

Have you ever had . . .

	Never 0	Infrequently 1	Sometimes 2	Most of Time 3	Always 4
1. Vaginal burning or itching?	0	1	2	3	4
2. Painful urination or increased frequency or urination?	0	1	2	3	4
3. Leaking of urine when coughing, laughing, sneezing, or on hard work?	0	1	2	3	4
4. Leaking of urine when walking, running, climbing steps, or on light work?	0	1	2	3	4
5. Leaking of urine, regardless of activity, even when in a lying position?	0	1	2	3	4