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### Hormone Evaluation

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Night Phone: \_\_\_\_\_ Height: \_\_\_\_\_

Email: \_\_\_\_\_ Gender  Male  Female Weight: \_\_\_\_\_

Do you use tobacco?  Yes  No How much & How often? \_\_\_\_\_

Do you use alcohol?  Yes  No How much & How often? \_\_\_\_\_

Do you use caffeine?  Yes  No How much & How often? \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Doctor's Phone: \_\_\_\_\_

Allergies: \_\_\_\_\_

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

### OTC (over-the-counter) Medications. Please check all products that you use occasionally or regularly.

- |   |   |
|---|---|
| <input type="checkbox"/> Pain Reliever                              | <input type="checkbox"/> Combination product (cough&cold reliever, example: Robitussin CF)  |
| <input type="checkbox"/> Aspirin                                    | <input type="checkbox"/> Sleep Aids (examples: Unisom, Sominex, Tylenol PM)                 |
| <input type="checkbox"/> Acetaminophen (example: Tylenol)           | <input type="checkbox"/> Antidiarrheals (examples: Imodium, Pepto Bismol, Kaopectate)       |
| <input type="checkbox"/> Ibuprofen (example: Motrin)                | <input type="checkbox"/> Laxatives/stool softeners (examples: Doxidan, Correctol, Dulcolax) |
| <input type="checkbox"/> Naproxen (example: Aleve)                  | <input type="checkbox"/> Diet aids/Weight loss products                                     |
| <input type="checkbox"/> Ketoprofen (example: Orudis KT)            | <input type="checkbox"/> Antacids (examples: Maalox, Mylanta)                               |
| <input type="checkbox"/> Cough Suppressant (example: Robitussin DM) | <input type="checkbox"/> Acid Blockers (examples: Tagamet, Pepcid, Zantac, Prilosec)        |
| <input type="checkbox"/> Antihistamine product (example: Benadryl)  | <input type="checkbox"/> Other: Please list: _____  |
| <input type="checkbox"/> Decongestant (example: Sudafed)            |   |

### Nutritional/Natural Supplements: Please check all products that you use occasionally or regularly.

- Vitamins (examples: multiple or single vitamins such as b complex, E, C, beta carotene, etc.)
- Minerals (examples: calcium, magnesium, chromium, etc.)
- Herbs (examples: Ginseng, Ginkgo Biloba, Echinacea, etc.)
- Enzymes (examples: Digestive formulas, papaya, bromelain, CoEnzyme Q10, etc.)
- Nutrition/Protein supplements (examples: shark cartilage, protein powders, amino acids, fish oils, etc.)
- Others (glucosamine, etc.) Please list: \_\_\_\_\_

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

- |   |  |
|---|--|
| <input type="checkbox"/> Heart Disease                            | <input type="checkbox"/> Blood Clotting Problems     |
| <input type="checkbox"/> High Cholesterol or lipids               | <input type="checkbox"/> Diabetes                    |
| <input type="checkbox"/> Cancer                                   | <input type="checkbox"/> Arthritis or joint problems |
| <input type="checkbox"/> Ulcers (stomach, esophagus)              | <input type="checkbox"/> Depression                  |
| <input type="checkbox"/> Thyroid disease                          | <input type="checkbox"/> Epilepsy                    |
| <input type="checkbox"/> Hormonal Related issues                  | <input type="checkbox"/> Headaches/Migraines         |
| <input type="checkbox"/> Lung condition (asthma, COPD, emphysema) | <input type="checkbox"/> Eye Disease (glaucoma, etc) |
| <input type="checkbox"/> Other: _____                             |  |
- 
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**If Breast Cancer, was it Hormone Positive?**       Yes       No

**If Thyroid Disease, please obtain a copy of your last thyroid profile.**

**Current Prescription Medications:**

Medication Name	Strength	Date Started	Directions
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List Hormones previously taken:	Date Started	Date Stopped	Reason
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Bone Size:  Small       Medium       Large

Body Type:     Estrogenic (pear)       Androgenic (apple)

Have you ever used oral contraceptives?     Yes       No

Any problems: \_\_\_\_\_

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How many pregnancies have you had? \_\_\_\_\_    How many children? \_\_\_\_\_

Have you had a hysterectomy?     Yes       No    Date of Surgery: \_\_\_\_\_  
Ovaries Removed?                     Yes       No

Have you had a tubal ligation?     Yes       No    Date of Surgery: \_\_\_\_\_

**Do you routinely exercise?**     Yes     No    **If Yes, what type and how often?** \_\_\_\_\_

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**Does your diet include the following?**

- Fresh Fruits
- Fresh Vegetables
- Whole Grains
- Frequent fast foods or high fat foods
- Processed Foods

**Do you suffer from insomnia?**     Yes     No

**Please rate your stress level:**     High     Moderate     Low

**Check any of the following that apply:**

- Family history of osteoporosis
- Sedentary lifestyle
- Smoker
- Steroid Use (Prednisone)
- Frequent missed periods (before menopause)
- Decreased exposure to sunlight
- Drink several carbonated drinks per day
- Drink several caffeinated drinks per day
- Low Body weight

**Check any of the following that apply:**

- Began menses before 12 years old
- Menopause after age 55
- First live birth after age of 30
- Family history of Breast Cancer
- Previous breast lump biopsy
- Previous Estrogen Replacement Therapy

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

- Uterine Cancer    Family Member: \_\_\_\_\_
- Ovarian Cancer    Family Member: \_\_\_\_\_
- Fibrocystic Breasts    Family Member: \_\_\_\_\_
- Heart Disease    Family Member: \_\_\_\_\_
- Breast Cancer    Family Member: \_\_\_\_\_
- Osteoporosis    Family Member: \_\_\_\_\_

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

Mammography     Yes     No    Date: \_\_\_\_\_

Pap Smear     Yes     No    Date: \_\_\_\_\_

Since you first began having periods, have you ever had what YOU would consider to be abnormal cycles?

Yes     No

If Yes, Please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

When was your last period? \_\_\_\_\_

How many days did it last? \_\_\_\_\_

Do you or have you ever had PMS?     Yes     No

If yes, explain symptoms: \_\_\_\_\_

What are your goals in taking BHRT?

\_\_\_\_\_

\_\_\_\_\_

# Hormone Replacement Therapy Patient Symptom 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	_____	_____	_____	_____