10. Hormone Replacement Medication History			
Please identify all the products you have used previously	**How Often? (e.g. # times per day)**	**Start/ Finish**	**Pharmacist's Comments**
□ **Estrogens** (e.g. Premarin®, C.E.S. ®, Estrace®, Ogen®, Delestrogen®)			
□ **Topical Estrogens** (e.g. Estrogel®, Vagifem, Estraderm®, Vivelle, Climara®, Estradot®, Premarin® Vag Cream, Tri-est)			
□ **Progestins** (e.g. Provera®, MPA, Depo-Provera®)			
□ **Progesterones** (e.g. Prometrium®, Progesterone Cream)			
□ **Combination Products** (e.g. FemHRT™, Premplus™, Estalis®, Estalis-Sequi®, Estracomb®)			
□ **Selective Estrogen Receptor Modulators** (e.g. Clomiphene, Tamoxifen, Evista®)			
□ **Other Hormonal Products** (e.g. Estring®, Mirena®, Plan B™, Cyclomen®, Pregnyl®, Profasi® HP, GnRH)			
□ **Testosterone** (e.g. Climacteron®, Andriol®)			

Hormone Replacement Therapy Specific Information

1. How did you arrive at the decision to consider Prescription Bio-identical Hormone Replacement Therapy?
   □ Doctor □ Self □ Friend/family member

2. Bone Size: □ Small □ Medium □ Large

3. Body Type: □ Androgenic (i.e.: boyish build, small breasts, narrow hips)

   □ Estrogenic (i.e.: girlish build, large breasts and hips)

4. Have you ever used oral contraceptives? □ NO □ YES 4a. If YES, any problems? □ NO □ YES
   Please describe: _____
   _____

5. How many pregnancies have you had? _____
   5a. Have you had trouble becoming pregnant or maintaining a pregnancy? □ NO □ YES
   5b. If YES, please explain:

_____
_____

6. Have you had a hysterectomy? □ NO □ YES
   6a. If YES, date of surgery: _____ □ Total □ Uterus only

7. Have you had a tubal ligation? □ NO □ YES

8. Do you have a family history of any of the following? Check all that apply:
   □ Uterine Cancer □ Ovarian Cancer □ Breast Cancer
   □ Heart Disease □ Osteoporosis

9. Were you prematurely gray? □ NO □ YES

10. 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: _____

11. Since you first began having periods, have you ever had what YOU would consider to be abnormal cycles? □ NO □ YES 11a. If YES, please explain (such as age when this occurred, symptoms…):

_____
_____

12. When was your last period? _____12a. How many days did it last? _____

13. Do you have, or did you ever have Premenstrual Syndrome (PMS)? □ NO □ YES
    13a. If YES, explain symptoms:

_____
_____

Hormone Replacement Therapy Patient Information Sheet

Name: _____ Today's Date: _____

Have you experienced any of the following symptoms recently? Please circle the number that best describes your experiences, with one being Extremely Mild and ten being Extremely Severe.

Sleep Disruptions	0	1	2	3	4	5	6	7	8	9	10
Fatigue	0	1	2	3	4	5	6	7	8	9	10
Vaginal Dryness	0	1	2	3	4	5	6	7	8	9	10
Irritability	0	1	2	3	4	5	6	7	8	9	10
Nervousness	0	1	2	3	4	5	6	7	8	9	10
Breast Tenderness	0	1	2	3	4	5	6	7	8	9	10
Hot Flashes	0	1	2	3	4	5	6	7	8	9	10
Dry Skin	0	1	2	3	4	5	6	7	8	9	10
Mood Swings	0	1	2	3	4	5	6	7	8	9	10
Arthritis	0	1	2	3	4	5	6	7	8	9	10
Loss of Recent Memory	0	1	2	3	4	5	6	7	8	9	10
Weight Gain	0	1	2	3	4	5	6	7	8	9	10
Decreased Sex Drive	0	1	2	3	4	5	6	7	8	9	10
Depression	0	1	2	3	4	5	6	7	8	9	10
Fluid Retention	0	1	2	3	4	5	6	7	8	9	10
Headaches	0	1	2	3	4	5	6	7	8	9	10
Night Sweats	0	1	2	3	4	5	6	7	8	9	10
Hair loss	0	1	2	3	4	5	6	7	8	9	10
Harder to Reach Climax	0	1	2	3	4	5	6	7	8	9	10
Bladder Symptoms	0	1	2	3	4	5	6	7	8	9	10
Other: _____	0	1	2	3	4	5	6	7	8	9	10

Question Documentation Form

Please write down any questions you may have about Prescription Bio-identical Hormone Replacement Therapy, other medications, or any other questions that come up as you read through the materials you have received. Bring this question sheet with you to your consultation so you can discuss this information with your pharmacist. Thank you.

1.

2.

3.

4.

5.