FINDING THE BALANCE

SYMPTOMS LIST CHART

PATIENT_____

DATE_____

LACK OF PROGESTERONE:

__HEADACHE
__YEAST INFECTIONS
__ANXIETY
__SWOLLEN BREASTS
__MOODINESS
__DEPRESSION
__IRRITABILITY
__INSOMNIA
__CRAMPS
__PAINFUL BREASTS
__WEIGHT GAIN
__BLOATING
__EARLY MENESTRATION
__PAINFUL JOINTS

LACK OF ESTROGEN:

__HOT FLASHES
__NIGHT SWEATS
__SLEEP DISORDERS
__VAGINAL DISORDERS
__DRY SKIN
__VAGINAL SHRINKAGE
__PAINFUL INTERCOURSE
__LACK OF MENESTRATION

LACK OF TESTOSTERONE:

__FATIGUE, PROLONGED
__MEMORY PROBLEMS
__DECREASED LIBIDO
__MUSCLE WEAKNESS
__BONE LOSS
__MENTAL FUZZINESS
__BLUNTED MOTIVATION
__DIMINISHED FEELING OF WELL BEING
__VAGINAL DRYNESS
__GENERAL ACHES/PAINS

CONFIDENTIAL HORMONE EVALUATION

MEDICAL HISTORY

Today's Date: _____

Name: _____ Birth date: _____ Age: ___

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Height: _____ Weight: _____

			How often and how much?
Do you use tobacco?	Yes	No	_____
Do you consume alcohol?	Yes	No	_____
Do you consume caffeine?	Yes	No	_____

Doctor's Name: **Address:** **Phone:**

_____

_____

_____

_____

Allergies: Please check all that apply.

__ Penicillin	__ Morphine	__ Dye Allergies	__ Pet Allergies
__ Codeine	__ Aspirin	__ Nitrate Allergy	__ Seasonal (Pollen) Allergies
__ Sulfa Drug	__ Food Allergies	__ No Known Allergies	__ Other: _____

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

_____

_____

Over the counter (OTC):

Please check all products that you use occasionally or regularly. Check all that apply.

__ Pain Reliever
__ Aspirin
__ Acetaminophen (example: Tylenol ®)
__ Ibuprofen (example: Motrin IB ®)
__ Naproxen (example: Aleve ®)
__ Ketoprofen (example: Orudis KT ®)
__ Cough suppressant (example: Robitussin DM ®)
__ Antihistamine product (example: Chlor-Trimeton ®)
__Decongestant product (example: Sudafed ®)
__Combination product (cough/cold reliever)
__Sleep aids: Excedrin PC ®, Unisom ® Sominex ® Nytal ®)
__Antidiarrheal (examples: Imodium ® Pepto Bismol ® Kaopectate ®)
__Laxatives/stool softeners (examples: Doxidan ® Correctol ®, etc.)
__Diet aids/weight loss products (example: Dextril ®)
__Antacids (examples: Maalox ® Mylanta ®)
__Acid blockers (examples: Tagamet HE ®, Pepcid C ®, Zantac 75 ®)
__Other (Please List
_____

Nutritional/ Natural Supplements: Please Identify and list the products you are using:

? Vitamins (examples: multiple or single vitamins such as B complex, E, C, beta carotene)
? Minerals (examples: calcium, magnesium, chromium, colloidal minerals, various single minerals)
? Herbs (examples: Ginseng, Ginkgo Biloba, Echinacea, other herbal medicinal teas, tinctures, remedies, etc.)
? Enzymes (examples: digestive formulas, papaya, bromelain, coenzyme Q10, etc.)
? Nutrition/protein supplements (examples: shark cartilage, protein powers, amino acids, fish oils, etc.)

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

__Heart disease (example: Congestive Heart Failure)
__High Cholesterol or lipids (examples: Hyperlipidemia)
__Cancer
__Ulcers (stomach, esophagus)
__Thyroid disease
__Hormonal related Issues
__Lung condition (example: asthma, emphysema, COPD)
__High blood pressure (example: Hypertension)
__Blood Clotting Problems
__Diabetes
__Arthritis or joint problems
__Depression
__Epilepsy
__Headaches/migraines
__Eye Disease (glaucoma, etc.)
__Other (Please specify): _____
_____
_____

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)
_____
_____
_____

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 of Surgery) _____

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

Uterine Cancer _____ Family member(s) _____
Ovarian Cancer_____ Family member(s) _____
Fibrocystic 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 No Yes Date: _____
PAP Smear No Yes Date: _____

Since you first began having periods, have you ever had what YOU 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:
_____
_____
_____

How did you arrive at the decision to consider Bio-Identical Hormone Replacement Therapy?

Doctor Self Friend/Family Member Other

What are your goals with taking BHRT?

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

BOULEVARD PHARMACEUTICAL COMPOUNDING CENTER

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Fax: (508) 795-0813

TEST REQUIRED FOR BHRT THERAPY
(BI-IDENTICAL HORMONE REPLACEMENT THERAPY)

NECESSARY TESTS:

1 ESTRADIOL
2 PROGESTERONE
3 TESTOSTERONE (FREE)
4 DHEA
5 CORTISOL (AM)
6 TSH (THYROID STIMULATING HORMONE)-MAY BE AVAILABLE FROM PAST LABS)

- **NOTE:** SERUM TESTS AND SALIVA TESTS MAY DIFFER WITH TOPICAL PREPARATIONS SINCE TOPICALS MISS THE FIRST LIVER BYPASS.

ADDITIONAL TEST THAT ARE HELPFUL FOR BOTH BHRT AND WEIGHT CONTROL:

1 T-3
2 T-4
3 SKIN TEST FOR IODINE
4 ZINC TEST
5 TEMPERATURE-
-TAKE WITH A DIGITAL THEMOMETER- (AM [BEFORE GETTING OUT OF BED], MID-DAY, AND EVENING)
-KEEP A RECORD, AND IF CONSISTANTLY LOWER THAN NORMAL INFORM YOUR PHYSICIAN.