Boudreaux's NEW DRUG STORE
The Problem Solvers
404 East Prien Lake Road - Lake Charles, LA
Phone: 337-436-7216 - Fax: 337-436-7217 - TF: 800-897-7724

HORMONE REPLACEMENT CONFIDENTIAL EVALUATION

The answers you provide to the questions on the following pages will allow the pharmacist to maintain your medical history and will help in advising you about current medical therapies. All information provided will be kept confidential.

Confidential Medical History Form

Please return your forms to Boudreaux's New Drug Store when you have completed them.
The Pharmacist will then schedule a consultation to meet with you to further discuss your information.

Today's Date:_____

Name:_____ Birth date:_____
Address:_____
Phone 1:_____ Phone 2: _____
e-Mail Address:_____
Occupation:_____ Full-time ❑ Part-time ❑ Retired ❑
Living Situation: Spouse ❑ Alone ❑ Children ❑ Partner ❑ Parents ❑ Other ❑
How did you arrive at the decision to consider Bio-Identical Hormone Replacement Therapy? Doctor ❑ Self ❑ Friends/Family Members ❑ Other ❑_____
Goals of Hormone Replacement: _____
_____
_____

Current Medical Status:

General Health: Excellent ❑ Good ❑ Fair ❑ Poor ❑ Height: _____Weight:____
Do you use tobacco? Yes ❑ No ❑ If yes, how much and how often?_____
Do you use alcohol? Yes ❑ No ❑ If yes, how much and how often? _____
Do you use caffeine? Yes ❑ No ❑ If yes, how much and how often? _____
Primary Physician:_____
Additional Clinicians: _____
_____
_____

Allergies:

Please list any allergies that you have and the reaction you experienced:

_____
_____
_____
_____

Dietary Habits and Exercise:

Dietary Restrictions: _____
Meal Choices (Be as specific as you can) :
Breakfast:_____
Lunch:_____
Dinner:_____

Do you get routine exercise?_____ What type(s)?_____
How often?_____ Do you belong to a fitness club?_____

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

❑ Heart Disease	❑ High Cholesterol	❑ High Blood Pressure
❑ Cancer	❑ Ulcers	❑ Thyroid Disease
❑ Lung Condition	❑ Arthritis	❑ Diabetes
❑ Arthritis	❑ Osteoporosis	❑ Epilepsy
❑ Depression	❑ Headaches/Migraines	❑ Eye Disease
❑ Fibrocystic Breasts	❑ Uterine Fibroids	❑ Other_____

Current Prescription Medications:

Medication Name Strength Date Started Times Per Day

1)_____

2)_____

3)_____

4)_____

5)_____

6)_____

7)_____

8)_____

List medications previously taken:

Medication Name Date Started Date Stopped Reason for Stopping

_____

_____

_____

_____

Vitamins/Nutritional Supplements/Herbals/etc:

_____

_____

_____

_____

Over the counter(OTC) products used on a regular basis:

_____

_____

_____

_____

_____

Gynecological History:

Please indicate the most recent results of the following test(s) that you have had done.

Test	Date last performed	Results
Mammography		
Pap Smear		
Bone Density Scan		
Cholesterol		

Have you ever had an abnormal pap smear?_____ Treatment_____
Age at first period?_____ Date of last period?_____
Are you sexually active?_____ Are you trying to get pregnant?_____
How many pregnancies have you had?_____ How many children?_____
Any interrupted pregnancies? ❑ Yes ❑ No If yes, please explain:_____
_____
Current Birth Control Method?_____ How long?_____
Have you ever used oral contraceptives? ❑ Yes ❑ No If yes, for how long? _____
Any problems? ❑ Yes ❑ No If yes, please explain:_____
_____

Menstrual History:

Average Cycle Length ❑ 21-25 days ❑ 26-32 days ❑ 33-45 days ❑ > 45 days
Average Bleeding Pattern ❑ Heavy → Medium → Light
❑ Light → Heavy → Medium → Light
❑ Heavy/Excessive Bleeding
❑ Extremely Light
❑ Premenstrual or Postmenstrual spotting

Menstrual Cramping ❑ Severe ❑ Normal (1-3 days on heavier flow days) ❑ None
Any changes in your current cycle? ❑ Yes ❑ No If yes, describe: _____
Any bleeding between periods? ❑ Yes ❑ No If yes, when?_____

Do you have or have you had Premenstrual Syndrome (PMS) or PMDD? ❑ Yes ❑ No
If yes, please explain symptoms:_____
_____
_____

Have you had a hysterectomy? ❑ Yes ❑ No Date: _____
Ovaries removed? ❑ Yes ❑ No / ❑ One ❑ Both Date:_____
Have you had a tubal ligation? ❑ Yes ❑ No Date:_____

Do you have a family history of any of the following? (Please list family member in the space)

Uterine cancer	❑	Osteoporosis	❑
Ovarian Cancer	❑	Blood Pressure	❑
Fibrocystic Breasts	❑	High Cholesterol	❑
Breast Cancer	❑	Depression	❑
Heart Disease	❑	Diabetes	❑

Thyroid Disease ❑ Other ❑

Name:_____ **Date:**_____

(Please circle the number that best describes your experiences with the following symptoms.)

	Absent									**Severe**
Sleep Disruptions	1	2	3	4	5	6	7	8	9	10
Irritability	1	2	3	4	5	6	7	8	9	10
Anxiety	1	2	3	4	5	6	7	8	9	10
Mood Swings	1	2	3	4	5	6	7	8	9	10
Depression	1	2	3	4	5	6	7	8	9	10
Fuzzy Thinking	1	2	3	4	5	6	7	8	9	10
Food Cravings	1	2	3	4	5	6	7	8	9	10
PMS	1	2	3	4	5	6	7	8	9	10
Menstrual Cramps	1	2	3	4	5	6	7	8	9	10
Heavy/Irreg. Menses	1	2	3	4	5	6	7	8	9	10
Headaches	1	2	3	4	5	6	7	8	9	10
Breast Tenderness	1	2	3	4	5	6	7	8	9	10
Breast Swelling	1	2	3	4	5	6	7	8	9	10
Fibrocystic Breasts	1	2	3	4	5	6	7	8	9	10
Fatigue	1	2	3	4	5	6	7	8	9	10
Weight Gain	1	2	3	4	5	6	7	8	9	10
Fluid Retention	1	2	3	4	5	6	7	8	9	10
Uterine Fibroids	1	2	3	4	5	6	7	8	9	10
Bloating	1	2	3	4	5	6	7	8	9	10
Hot Flashes	1	2	3	4	5	6	7	8	9	10
Night Sweats	1	2	3	4	5	6	7	8	9	10
Dry Skin/Hair	1	2	3	4	5	6	7	8	9	10
Vaginal Dryness	1	2	3	4	5	6	7	8	9	10
Memory Loss	1	2	3	4	5	6	7	8	9	10
Hair Loss	1	2	3	4	5	6	7	8	9	10
Bladder Symptoms	1	2	3	4	5	6	7	8	9	10
Yeast Infections	1	2	3	4	5	6	7	8	9	10
Vaginal Shrinking	1	2	3	4	5	6	7	8	9	10
Painful Intercourse	1	2	3	4	5	6	7	8	9	10
Decreased Sex Drive	1	2	3	4	5	6	7	8	9	10
Harder to climax	1	2	3	4	5	6	7	8	9	10

Additional Comments/Concerns:

_____

_____

_____