



Women's Health Hormone Self-Assessment

Knowledge Changes Everything: Quality | Innovation | Experience | Since 1974

Consulting Pharmacist: _____ Consultation Date: _____

How did you hear about College Pharmacy's Hormone Self-Assessment & Consultation Services?

Advertisement _____	Books/Articles _____
Another Patient _____	Website _____
Healthcare Provider _____	Other (please specify) _____

Personal Information

Patient Name: _____ Date: _____

Address: _____ DOB _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Do you understand what Biologically Identical Hormone Replacement is? _____

Do you understand the risks involved due to your use of Biologically Identical Hormone Replacement such as myocardial infarction, heart disease, stroke, breast cancer? _____

**It is recommended that you consult with your physician regarding these risks.*

What are your goals for Biologically Identical Hormone Replacement? _____

Medical History

Family History	(relationship)
Cancer (type) _____	_____
Heart Disease _____	_____
Diabetes _____	_____
High Blood Pressure _____	_____
Osteoporosis _____	_____
Other _____	_____

Medical History

Personal History

- | | | |
|--|--|--|
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Fibrocystic Breasts | <input type="checkbox"/> Ovarian Cysts |
| <input type="checkbox"/> Uterine Fibroids | <input type="checkbox"/> Abnormal Vaginal Bleeding | <input type="checkbox"/> PCOS |
| <input type="checkbox"/> Smoking History | <input type="checkbox"/> Stroke | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Impaired Liver Function | <input type="checkbox"/> Thrombophlebitis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Osteoporosis |

Cholesterol Serum: _____ Date: _____ Triglycerides: _____ HDL: _____ LDL: _____ Chol/HDL Ratio: _____

Bone density scan results: _____ Date: _____

Current Health Care Provider/s: _____

To what degree do you experience the following?

	None	Slightly	Moderate	Severe	Extreme
Difficulty Concentrating					
Can't Sleep (Insomnia)					
Depressed or Unhappy					
Anxious					
Headaches					
Moodiness/Emotional Swings					
Painful or Swollen Breasts					
Weight gain/ Bloating					
PMS					
	None	Slightly	Moderate	Severe	Extreme
Night Sweats					
Difficulty Remembering Things					
Brain Fog					
Hot Flashes					
Vaginal Dryness					
Dry Hair/Skin					
Incontinence					
Frequent Urinary Tract Infections					
Inability to Reach Orgasm					
Painful Intercourse					
Lack of Sexual Desire					
Fatigue/Loss of Energy					

General Health & Lifestyle

General Health: Good Fair Poor

Height: _____ Weight: _____ Do you exercise, describe: _____

Menstrual Cycle: None Regular _____ Date of last period: _____

Irregular / Explain (heavy, how long, etc): _____

Surgery:

- Oophorectomy
- Hysterectomy
- Tubal Ligation
- Other
- None

Date of Surgery:

_____ (ovaries)
_____ (uterus)

Current Medications & Reason: _____

Current Vitamins / Minerals / Herbal Formulas: _____

Prior Hormone Replacement Therapy History: (include dates of use) _____

Known Allergies (drug, food, pollen): _____

Are you currently following a special diet (Gluten Free, Casien Free, Arkins, Paleo, etc): _____

Do you eat/drink soy: _____ Caffeine/amount per day: _____ Alcohol/amount per day: _____

Notes and/or Questions:

BHRT Considerations

BHRT Dosage Form

Would you like your prescription filled using a:

- Topical gel applied once daily to inner arms or thighs.
 Sublingual tablets dissolved under the tongue twice daily.

It is recommended that baseline hormone levels be checked. This can be achieved by testing blood, urine, or saliva. If recommended, we suggest that you test for the following hormones:

Women (For overall health check a,b, and c yearly.)

- | | |
|--------------------------------|--|
| a. Pap Smear | f. Estradiol, and Estrone |
| b. Thyroid: TSH, T3, and T4 | g. DHEA (Sulfate) |
| c. Cortisol | h. Vitamin D3 (25 Hydroxy) |
| d. Testosterone (Free & Total) | |
| e. Progesterone | Optional: Reverse T3 (practitioner discretion) |

If you have recently (2 to 3 months) had a blood, urine, or saliva hormone test, please attach the results to your questionnaire.

Where to go from here:

- I would like a recommendation from a pharmacist.
 I will take this completed questionnaire to my practitioner.
 I will contact my practitioner about further lab testing.

Notes and/or Questions:

Where to send your completed Hormone Self-Assessment:

1.) You will need to call College Pharmacy to set-up a consultation.

Email: The pharmacist that you schedule a consultation with can provide you with their email address.
Do not email this form to info@collegepharmacy, inforequest@collegepharmacy, or hipaamail@collegepharmacy.

Fax: Confirm with the consulting pharmacist that you will be sending this form via fax.
Toll-Free:(800) 556-5893 Colorado Springs Area: (719) 262-0035

Local? You can bring it with you!

Waiver & Privacy Information

Waiver **Last Revised May 2012**
 I hereby release College Pharmacy, all its employees and pharmacists from any and all liability whatsoever associated with or connected to my Biologically Identical Hormone Replacement Therapy (BHRT) consultation and/or use of BHRT. I acknowledge that I am legally responsible for and aware of the potential side-effects associated with BHRT. I understand that no doctor, nurse, pharmacist, or administrative personnel can guarantee that BHRT will provide the results I seek. I am participating in this program by my own choice, and assume all responsibility for my use of BHRT.

I fully understand that it is my responsibility to have an annual physical examination along with appropriate laboratory testing. I am currently under the medical supervision of a primary care physician. I have been advised in this hormone self-assessment about the increased risks of heart disease, myocardial infarction, stroke, and breast cancer possibly associated with the use of BHRT. I have answered truthfully all of the questions on this questionnaire.

Signed _____ Date _____

Privacy Agreement
 Starting April 14, 2003, healthcare providers must comply with a new set of federal regulations. The regulations are part of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), which addresses your rights to privacy and handling of Protected Health Information ("PHI").

Respect for your privacy is a top priority at College Pharmacy. Concern for your privacy rights goes hand in hand with our focus on maintaining and improving your health. One of the regulations requires that all of our patients receive our Notice of Privacy Practices at the time of, or prior to, our providing healthcare services. We are also required to ask each patient to sign an acknowledgment indicating receipt of this notice.

In an effort to ensure that there will not be a delay on your first prescription from College Pharmacy, and that you are provided with prompt service, we ask that you read our Notice of Privacy Practices, sign the Acknowledgment form at the bottom of the page and return to us.

For Privacy Agreement Questions, please contact:
 Privacy Officer
 College Pharmacy
 3505 Austin Bluffs Parkway, Suite 101
 Colorado Springs, CO 80918
 Fax: 719/262-0035 or 800/556-5893
 e-mail: hipaamail@collegepharmacy.com

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
 College Pharmacy 3505 Austin Bluffs Pkwy #101 Colorado Springs, CO 80918

Patient Last Name	Patient First Name	M.I.
Street Address	City	State
Zip	() Telephone Number	

My signature below certifies that I have been provided with a copy of the above named pharmacy's Notice of Privacy Practices.

 Patient Signature (or authorized representative) _____
Date