

Women's Hormone Self Assessment Questionnaire

Patient Name: _____ Date: _____

Address: _____ DOB: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

How did you hear about Biologically Identical Hormone Replacement and College Pharmacy?

Advertisement _____ Books/Articles _____

Another Patient _____ Internet _____

Healthcare Provider _____ Other (please specify) _____

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 _____

Personal History

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

Cholesterol: _____ Date: _____ Results: _____

Bone density scan _____ Date: _____ Results: _____

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					
Hot Flashes					
Vaginal Dryness					
Dry Hair/Skin					
Incontinence					
Frequent Urinary Tract Infections					
Inability to Reach Orgasm					
Painful Intercourse					
	None	Slightly	Moderate	Severe	Extreme
Lack of Sexual Desire					
Fatigue/Loss of Energy					

General Health:

- Good
- Fair
- Poor

Height: _____

Weight: _____

Periods:

- None
- Regular _____
- Irregular _____
- Date of last period _____

Explain (heavy, how long, etc) _____

Surgery:

- Oophorectomy
- Hysterectomy
- Tubal Ligation
- None

Date of Surgery:

_____ (ovaries)
_____ (uterus)

Current Medications: (including vitamins, herbals, etc.) _____

HRT History: (include dates of use) _____

Allergies: (drug, food, pollen): _____

Notes and/or Questions:

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 sometimes 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: Estradiol & Estrone, Progesterone, Free and Total Testosterone, DHEA (Sulfate), Cortisol, Vitamin D3 (25 Hydroxy) and Thyroid (TSH, T3, T4).

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 would like to order the appropriate Hormone Saliva Testing from College Pharmacy.
- I will contact my practitioner about further lab testing.

Notes and/or Questions:



Waiver

Last Revised October 2003

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 questionnaire 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, health care 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. We believe this philosophy is a large part of what has made you loyal to College Pharmacy.

One of the new regulations requires that all of our patients receive our Notice of Privacy Practices at the time of or prior to our providing health care services. We are also required to ask each patient to sign an acknowledgment indicating receipt of this notice.

In an effort to insure that on your first prescription from College Pharmacy after April 14, 2003 there will be no delay in providing you with the prompt service you have come to expect, we ask that you take time to read the enclosed Notice of Privacy Practices, sign the Acknowledgment form at the bottom of the page and return by e-mail, fax or mail to:

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

If you have questions regarding this letter or privacy issues in general, please contact me at 719/262-0022.

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 written copy of the above named pharmacy's Notice of Privacy Practices.

Patient Signature (or authorized representative) Date

College Pharmacy

3505 Austin Bluffs Pkwy. Ste. 101

Colorado Springs, CO 80918

Phone: (800) 888-9358 ext. 192

(719) 262-0022 ext. 192

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