KORU PHARMACY
NUTRITION | WELLNESS

PCAB ACCREDITED Compounding Pharmacy
A SERVICE OF ACHC

CONFIDENTIAL HORMONE EVALUATION

Today's Date: _____

Name: _____Birthdate: _____Age:_____

Address: _____
Street City State Zip

Phone:_____Email:_____

Height: _____ Weight: _____ Desired Weight: _____

How often and how much?

Do you use tobacco? ☐Yes ☐No _____

Do you use alcohol? ☐Yes ☐No _____

Do you use caffeine? ☐Yes ☐No _____

Do you exercise? ☐Yes ☐No _____

Allergies: Please list any allergies and describe the reaction that occurred
Drugs: _____
Foods: _____
Other: _____

Over-the-Counter Medication History: Please list all non-prescription medications that you are taking. (Include vitamins, herbals, and supplements):

_____
_____
_____
_____

Current Prescription Medications (including hormones):
Medication name | Strength | Date started | How often per day

_____
_____
_____
_____
_____

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Menstrual History

Age at first period_____ Date of last menstrual period_____
Length of cycle_____ Time between cycles_____

Menstrual Cramping? ☐Yes ☐No

Menstrual Pain? ☐Yes ☐No

Have you ever had premenstrual problems (bloating, breast tenderness, irritability, etc.)? ☐Yes ☐No
If yes, please describe:_____

Do you have other problems with your periods (heavy, irregular, spotting, skipping, etc.)? ☐Yes ☐No
*If yes, please describe:*_____

Use of hormonal birth control: ☐Birth control pills ☐Patch ☐NuvaRing ☐Other_____
Date started: _____

Any problems with hormonal birth control? ☐Yes ☐No
*If yes, explain*_____

Use of other contraception? ☐Yes ☐No ☐Condoms ☐Diaphragm ☐IUD ☐Partner vasectomy

Obstetric History

☐Pregnancies_____ ☐Miscarriages_____ ☐ Children_____

☐Hysterectomy _____ ☐Oophorectomy _____

Did you develop any problems in or after pregnancy, for example, toxemia (high blood pressure), diabetes, post-partum depression, issues with breast feeding, etc.? ☐Yes ☐No
If yes, please explain:

_____
_____

Last Pap test:_____ ☐Normal ☐Abnormal

Last mammogram: _____ ☐Normal ☐Abnormal

Last bone density: _____ Results: _____ ☐Normal ☐High ☐Low

Other tests and dates: _____

Other Gynecological Symptoms: *(Check if applicable)*

☐Endometriosis ☐Infertility ☐Fibrocystic breasts ☐Vaginal infection ☐Fibroids

☐Ovarian cysts ☐Pelvic inflammatory disease ☐Reproductive cancer

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Menopause History

Are you in menopause? ☐Yes ☐No *If yes, age at last period*:_____

Was it surgical menopause? ☐Yes ☐No *If yes, explain:* _____

Do you currently have symptomatic problems with menopause? *(Check all that apply)*

☐Hot flashes ☐Mood swings ☐Concentration/memory problems ☐Headaches ☐Joint pain

☐Vaginal dryness ☐Weight gain ☐Decreased libido ☐Loss of control of urine ☐Palpitations

Are you on hormone replacement therapy? ☐Yes ☐No

If yes, for how long and for what reason (hot flashes, osteoporosis prevention, etc.)?_____

_____

Current Hormone Usage:

Do you take hormones of any kind? ☐Yes ☐No

If so, list (include birth control pills, HRT, or natural hormone (s): Brand

Hormone	Dose	How Often	Date Started

If you are currently taking hormones, **what specific symptoms are improved?** *Please list:*

If you are currently taking hormones, **are you experiencing any unwanted side effects?** *Please list:*

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Symptoms Questionnaire

	Absent	Mild	Moderate	Severe
Hot Flashes	_____	_____	_____	_____
Night Sweats	_____	_____	_____	_____
Vaginal Dryness	_____	_____	_____	_____
Incontinence	_____	_____	_____	_____
Bleeding Changes	_____	_____	_____	_____
Fibrocystic Breast	_____	_____	_____	_____
Weight Gain (waist)	_____	_____	_____	_____
Weight gain (hips)	_____	_____	_____	_____
Fluid Retention	_____	_____	_____	_____
Dry skin/hair	_____	_____	_____	_____
Thinning skin	_____	_____	_____	_____
Hair Loss	_____	_____	_____	_____
Brittle/dry nails	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Mood Swings	_____	_____	_____	_____
Irritability	_____	_____	_____	_____
Headaches	_____	_____	_____	_____
Breast Tenderness	_____	_____	_____	_____
Cramps	_____	_____	_____	_____
Insomnia	_____	_____	_____	_____
Sleep disturbances	_____	_____	_____	_____
Fatigue	_____	_____	_____	_____
Loss of Memory	_____	_____	_____	_____
Foggy Thinking	_____	_____	_____	_____
Acne	_____	_____	_____	_____
Oily skin	_____	_____	_____	_____
Sugar cravings	_____	_____	_____	_____
Bone loss	_____	_____	_____	_____
Decreased muscle mass	_____	_____	_____	_____
Increased facial/body hair	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Low libido	_____	_____	_____	_____
Heart palpitations	_____	_____	_____	_____
Low blood pressure	_____	_____	_____	_____
Slow pulse rate	_____	_____	_____	_____
Swelling/puffy eyes/face	_____	_____	_____	_____
Stress	_____	_____	_____	_____
Candida infection	_____	_____	_____	_____
Cold hands/feet	_____	_____	_____	_____

Other: _____

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Primary Care Physician: _____

Phone: _____ Fax: _____

Medical History

Please check appropriate box if applicable and provide date of onset

GASTROINTESTINAL **Date of onset:**

- Irritable Bowel Syndrome _____
- Inflammatory Bowel Disease _____
- Crohn's disease _____
- Ulcerative Colitis _____
- Gastritis or Peptic Ulcer Disease _____
- GERD (reflux) _____
- Celiac Disease _____
- Other _____

CANCER

- Lung cancer _____
- Breast cancer _____
- Colon cancer _____
- Ovarian cancer _____
- Prostate cancer _____
- Skin cancer _____

GENITAL AND URINARY SYSTEMS

- Kidney stones _____
- Gout _____
- Interstitial cystitis _____
- Frequent urinary tract infections _____
- Frequent yeast infections _____
- Erectile/sexual Dysfunction _____
- Other:_____ _____

MUSCULOSKELETAL/PAIN

- Osteoarthritis _____
- Fibromyalgia _____
- Chronic Pain _____
- Other: _____ _____

FAMILY HISTORY (*please specify relationship)*

- Breast cancer _____
- Ovarian cancer _____
- Uterine cancer _____
- Fibrocystic breast _____
- Heart disease _____
- Osteoporosis _____
- Diabetes _____

CARDIOVASCULAR **Date of onset:**

- Heart Attack _____
- Other Heart Disease _____
- Stroke _____
- Elevated Cholesterol _____
- Arrhythmia (irregular heart rate) _____
- Hypertension (high blood pressure) _____
- Rheumatic Fever _____
- Mitral Valve Prolapse _____
- Other: _____ _____

INFLAMMATORY/AUTOIMMUNE

- Chronic Fatigue Syndrome _____
- Rheumatoid Arthritis _____
- SLE _____
- Immune Deficiency Disease _____
- Herpes-Genital _____
- Infectious Disease _____
- Poor immune function _____
- Frequent infections _____
- Other: _____ _____

SKIN CONDITIONS

- Eczema _____
- Psoriasis _____
- Acne _____
- Melanoma _____
- Rosacea _____

MEN'S HISTORY (*for men only)*

- Prostate Enlargement _____
- Prostate infection _____
- Change in Libido _____
- Impotence _____
- Difficulty obtaining an erection _____
- Difficulty maintaining an erection _____
- Nocturia (urination at night) _____
  How many times at night? _____
- Urgency/Change in Urinary Stream _____
- Loss of Control of Urine _____

Have you had a PSA done? ☐Yes ☐No

PSA Level: ☐0-2 ☐2-4 ☐4-10 ☐>10

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