Heritage Compounding Pharmacy
2903 Saturn St, Suite A
Brea, CA 92821
Tel: (714) 579-1636
Fax: (714) 579-1682
Esther Kim Pharm. D. – Compounding Specialist

MEDICAL HISTORY EVALUATION

Please return your form to the Pharmacy.
The Pharmacist will discuss with you to review your information. Thank you.

Today's Date: ____________________

Name: ___________________________________**Birthdate:** ___________ **Age:** _____

Address:____

City: ______________________________________ **State:** ______ **Zip:** _____________

Phone: ___________________ **E-Mail Address:** ________________________________

Gender: Male Female **Height:** _________ **Weight:** __________

If Yes, how often &how much?
- Do you use tobacco? Yes No ___________________________________
- Do you use alcohol? Yes No ___________________________________
- Do you use caffeine? Yes No ___________________________________

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

____

Allergies: Please check all that apply. ___ **No Known Allergies**
- ___ penicillin ___ morphine ___ dye allergies ___ pet allergies
- ___ codeine ___ aspirin ___ nitrate allergy ___ seasonal (pollen) allergies
- ___ sulfa drug ___ food allergies other: _______________________________

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

____

____

Over-the-counter (OTC) issues:
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)(example: Triaminic DM®)
___ Sleep aids (exmples: Excedrin PC®, Unisom®, Sominex®, Nytol®)
___ Antidiarrheals (examples:Imodium®, Pepto Bismol®, Kaopectate®)
___ Laxatives/stool softeners (examples: Doxidan®, Correctol®, etc.)
___ Diet aids/weight loss products (example: Dexatril®)
___ Antacids (examples: Maalox®, Mylanta®)
___ Acid blockers (examples: Tagamet HB®, Pepcid C®, Zantac 75®)
___ Other (please list)
____

Patient's Name_______________________________________

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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.)
others (glucosamine, etc.)

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

___ Heart disease (example: Congestive Heart Failure)
___ High cholesterol or lipids (examples: Hyperlipidemia)
___ High blood pressure (example: Hypertension)
___ Cancer
___ Ulcers (stomach, esophagus)
___ Thyroid disease
___ Hormonal Related Issues
___ Lung condition (example: asthma, emphysema, COPD)
___ Blood Clotting Problems
___ Diabetes
___ Arthritis or joint problems
___ Depression
___ Epilepsy
___ Headaches/migraines
___ Eye Disease (glaucoma, etc.)
___ Other: Please list: ____________________________

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) __________________________

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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?
Circle 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 would 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?

____

____

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HORMONE REPLACEMENT THERAPY PATIENT INFORMATION SHEET

	ABSENT	MILD	MODERATE	SEVERE
Fibrocystic Breast	□	□	□	□
Weight Gain	□	□	□	□
Heavy/Irregular menses	□	□	□	□
Hot Flashes	□	□	□	□
Dry Skin/Hair	□	□	□	□
Anxiety	□	□	□	□
Depression	□	□	□	□
Night Sweats	□	□	□	□
Vaginal Dryness	□	□	□	□
Headaches	□	□	□	□
Irritability	□	□	□	□
Mood Swings	□	□	□	□
Breast Tenderness	□	□	□	□
Sleep Disturbances/Insomnia	□	□	□	□
Cramps	□	□	□	□
Fluid Retention	□	□	□	□
Breakthrough Bleeding	□	□	□	□
Fatigue	□	□	□	□
Loss of Memory	□	□	□	□
Bladder Symptoms	□	□	□	□
Arthritis	□	□	□	□
Harder to Reach Climax	□	□	□	□
Decreased Sex Drive	□	□	□	□
Hair Loss	□	□	□	□

Patient’s Name____