



P I N E
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Bio-Identical Hormone Replacement Therapy Assessment and Evaluation Checklist

These items must be completed and on file with the pharmacy prior to your assessment:

Have your doctor complete the Pharmacist-Physician Collaboration Agreement.

Pharmacy Record Release Authorization Form

Confidential Medical History Form

Hormone Replacement Therapy Patient Information Sheet

Question Documentation Form

Provide copies of any relevant blood and/or saliva tests results if available (ie. estradiol, estriol, estrone, progesterone, testosterone, cortisol, etc.)

Mail all materials and a personal check or money order for the Assessment and Evaluation fee (\$75) made out to Pine Pharmacy.

Pharmacist-Physician Collaboration Agreement

Your patient, _____, has requested a *Bio-Identical Hormone Assessment* by our pharmacists. This assessment includes but is not limited to a review of symptoms, medical history, family history, and any pertinent lab work. Upon completion, recommendations and suggestions will be forwarded to you for review and approval. Recommendations may include prescriptions for bio-identical hormones, nutritional supplements, and lifestyle modifications.



I, _____ (Physician's Name) authorize Pine Pharmacy to assess and evaluate _____ (Patient Name), and make recommendations to me regarding my patient's bio-identical hormone treatment.

Signature: _____ Date: _____

Pharmacy Record Release Authorization

I, the undersigned patient authorize my pharmacist to release my personal medication and/or other medical information to the following persons or organizations upon request or as deemed necessary:

Name	Address	Telephone
1)		
2)		
3)		

I understand that employees of Pine Pharmacy will protect my privacy and this information will be released to other health care professionals only when it is necessary in order to provide health care services to me. This authority shall continue until revoked by me in writing.

Patient Name: _____

Address: _____

City, State, Zip _____

Phone: _____

Signature: _____

Date: _____

Patient Name: _____

Confidential Medical History Form

Please return your form to the Pharmacy when you have finished.
The Pharmacist will meet with you to review your information. Thank you.

Name: _____ Today's Date: _____
Birthdate: _____ Age: _____
Address: _____
City: _____ ST: _____ Zip: _____
Phone: _____ Email: _____
Gender: Female Male Height: _____ Weight: _____
Do you use tobacco? Yes or No If YES, how often & how much?
Do you use alcohol? _____
Do you use caffeine? _____

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

Allergies: Please check all that apply:

Penicillin Morphine Dye allergies Pet allergies
 Codeine Aspirin Nitrate allergies Seasonal (pollen)
 Sulfa drug Food allergies No known 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 Combination product, cough+cold reliever (ex:Triaminic®)
 Aspirin Sleep aids (ex:Excedrin PM®, Unisom®, Sominex®)
 Acetaminophen (ex:Tylenol®) Antidiarrheals (ex:Imodium®,PeptoBismol®, Kaopectate®)
 Ibuprofen (ex:Motrin IB®) Laxatives/stool softeners (ex:Doxidan®, Correctol®)
 Naproxen (ex:Aleve®) Diet aids/weight loss products (ex:Dexatrim®)
 Ketoprofen (ex:Orudis KT®) Antacids (ex:Maalox®, Mylanta®)
 Cough suppressant (ex:Robitussin DM®) Acid blockers (ex:Tagamet HB®,Pepcid AC®,Zantac 75®)
 Antihistamine product (ex:Chlor-Trimeton®) Other (please list:)
 Decongestant product (ex:Sudafed®) _____

Nutritional/Natural Supplements: Please identify and list the products you are using:

____ Vitamins (ex: multiple or single vitamins such as B complex, E, C, beta carotene)

____ Minerals (ex: calcium, magnesium, chromium, colloidal minerals, various single minerals)

____ Herbs (ex: Ginseng, Ginkgo Biloba, Echinacea, other herbal medicinal teas, tinctures, remedies, etc)

____ Enzymes (ex: digestive formulas, papaya, bromelain, CoEnzyme Q10, etc)

____ Nutrition/protein supplements (ex: shark cartilage, protein powders, amino acids, fish oils, etc)

____ Others (ex: glucosamine, etc.)

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

____ Heart disease (ex: Congestive Heart Failure)	____ Lung condition (ex: asthma, emphysema, COPD)
____ High cholesterol or lipids (ex: Hyperlipidemia)	____ Diabetes
____ High blood pressure (ex: Hypertension)	____ Arthritis or joint problems
____ Cancer	____ Depression
____ Ulcers (stomach, esophagus)	____ Epilepsy
____ Thyroid disease	____ Headaches/migraines
____ Hormonal related issues	____ Eye disease (glaucoma, etc)
____ Blood clotting problems	____ Other: Please list: _____

Current Prescription Medications:

	Medication Name	Strength	Date Started	How often per day
1	_____	_____	_____	_____
2	_____	_____	_____	_____
3	_____	_____	_____	_____
4	_____	_____	_____	_____
5	_____	_____	_____	_____
6	_____	_____	_____	_____

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, please describe below.

How many pregnancies have you had? _____ How many children? _____

Any interrupted pregnancies? _____ No _____ Yes

Patient Name: _____

Have you had a hysterectomy? _____ No _____ Yes Date of surgery _____

Ovaries removed? _____ No _____ Yes

Have you had a tubal ligation? _____ No _____ Yes Date _____

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?

Check those that apply and note the 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 consider to be abnormal cycles?

_____ No _____ Yes Date: _____

Please explain:

When was your last period? _____

How long did it last? _____

Do you have, or did you ever have Premenstrual Syndrome (PMS)? _____ No _____ Yes

If YES, please 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?

Patient Name: _____

Hormone Replacement Therapy Patient Information Sheet

Name _____

Have you experienced any of the following symptoms recently? Please circle the number that best describes your experiences with one being Extremely Mild and ten being Extremely Severe.

	1	2	3	4	5	6	7	8	9	10
Sleep Disruptions	1	2	3	4	5	6	7	8	9	10
Fatigue	1	2	3	4	5	6	7	8	9	10
Vaginal Dryness	1	2	3	4	5	6	7	8	9	10
Irritability	1	2	3	4	5	6	7	8	9	10
Nervousness	1	2	3	4	5	6	7	8	9	10
Breast Tenderness	1	2	3	4	5	6	7	8	9	10
Hot Flashes	1	2	3	4	5	6	7	8	9	10
Dry Skin	1	2	3	4	5	6	7	8	9	10
Mood Swings	1	2	3	4	5	6	7	8	9	10
Arthritis	1	2	3	4	5	6	7	8	9	10
Loss of Recent Memory	1	2	3	4	5	6	7	8	9	10
Weight Gain	1	2	3	4	5	6	7	8	9	10
Decreased Sex Drive	1	2	3	4	5	6	7	8	9	10
Depression	1	2	3	4	5	6	7	8	9	10
Fluid Retention	1	2	3	4	5	6	7	8	9	10
Headaches	1	2	3	4	5	6	7	8	9	10
Night Sweats	1	2	3	4	5	6	7	8	9	10
Hair Loss	1	2	3	4	5	6	7	8	9	10
Harder to Reach Climax	1	2	3	4	5	6	7	8	9	10
Bladder Symptoms	1	2	3	4	5	6	7	8	9	10
Other:	1	2	3	4	5	6	7	8	9	10

Question Documentation Form

Please write down any questions you may have about Prescription Bio-Identical Hormone Replacement Therapy (Rx BHRT), other medications, or any other questions that come up as you read through the materials you have received. Bring this question sheet with you to your consultation so you can discuss this information with your pharmacist/nurse. Thank you.

1.

2.

3.

4.

5.

Patient Name:

Frequently Asked Questions

Q: When will I be contacted after submitting all of the materials?

A: It is not uncommon to wait 2 weeks before receiving initial therapy recommendations. At the time Pine Pharmacy receives the materials an assessment and evaluation is performed. You will be contacted with any questions. A formal assessment and plan with therapy recommendations is sent to your doctor. Once authorization from your doctor is received you will be contacted with your treatment regimen.

Q: After my initial treatment regimen, how am I monitored?

A: Our pharmacists are always available for questions during normal business hours. After 90 days you will receive a follow-up questionnaire. Monitoring from that point on will annually or as needed.

Q: How long before I notice symptomatic relief.

A: Symptomatic relief varies depending on the symptom and specific hormone regimen, anywhere from days to several weeks in certain situations.

Q: Are there any side effects?

A: As with any medication there is always a possibility of side effects. The pharmacist will consult you on these possibilities.

Q: What dosage forms do you provide?

A: Bio-Identical hormones are commonly compounded into capsules, creams and lozenges. The pharmacist and physician will determine the most appropriate and convenient dosage form for you.

Q: Is the Assessment and Evaluation fee covered by my insurance?

A: No.

Q: Are the prescriptions covered by my insurance?

A: Many are but depending on the insurance and specific hormone prescribed, individual coverage benefits may vary.

Q: Do I need blood or saliva tests?

A: No, we take any lab work into consideration if available, but if not, treatment recommendations are made based on the clinical picture, including but not limited to family history, past medical history, and symptoms.