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.

Today's Date: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____

City: _____ ST: _____ Zip: _____

Phone: _____ Email: _____

Gender: ☐ Female ☐ Male Height: _____ Weight: _____

	Yes or No	If YES, how often & how much?
Do you use tobacco?		
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)
____ High cholesterol or lipids (ex: Hyperlipidemia)
____ High blood pressure (ex: Hypertension)
____ Cancer
____ Ulcers (stomach, esophagus)
____ Thyroid disease
____ Hormonal related issues
____ Blood clotting problems
____ Lung condition (ex: asthma, emphysema, COPD)
____ 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
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	○	○	○	○	○	○	○	○	○	○
Fatigue	○	○	○	○	○	○	○	○	○	○
Vaginal Dryness	○	○	○	○	○	○	○	○	○	○
Irritability	○	○	○	○	○	○	○	○	○	○
Nervousness	○	○	○	○	○	○	○	○	○	○
Breast Tenderness	○	○	○	○	○	○	○	○	○	○
Hot Flashes	○	○	○	○	○	○	○	○	○	○
Dry Skin	○	○	○	○	○	○	○	○	○	○
Mood Swings	○	○	○	○	○	○	○	○	○	○
Arthritis	○	○	○	○	○	○	○	○	○	○
Loss of Recent Memory	○	○	○	○	○	○	○	○	○	○
Weight Gain	○	○	○	○	○	○	○	○	○	○
Decreased Sex Drive	○	○	○	○	○	○	○	○	○	○
Depression	○	○	○	○	○	○	○	○	○	○
Fluid Retention	○	○	○	○	○	○	○	○	○	○
Headaches	○	○	○	○	○	○	○	○	○	○
Night Sweats	○	○	○	○	○	○	○	○	○	○
Hair Loss	○	○	○	○	○	○	○	○	○	○
Harder to Reach Climax	○	○	○	○	○	○	○	○	○	○
Bladder Symptoms	○	○	○	○	○	○	○	○	○	○
Other:	○	○	○	○	○	○	○	○	○	○

_____

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.