PREMIER SPECIALTY PHARMACY
11720 Medlock Bridge Rd. #162
Johns Creek, GA 30097
Phone: 770-622-8901 **FAX: 770-622-8900**

CONFIDENTIAL FEMALE HORMONE EVALUATION

Please fill out completely, then fax to:
Premier Specialty Pharmacy
Attn: Buffy Gougelmann, PharmD
Once received, we will contact you to schedule your hormonal consultation either in person or by phone.

Today's Date: _____

Name: _____ **Birthdate:** _____ **Age:** _____

Address: _____
Street City State Zip

Primary Phone: _____ **Primary Email:** _____

Height: _____ Weight: _____ Desired Weight: _____

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

_____
_____
_____

			If **YES**, 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): _____
_____
_____
_____
_____
_____

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Medical Conditions/Diseases: Please list any conditions/diseases that you have been diagnosed with or suffer from. (Examples include: Heart disease, high blood pressure, depression, ulcers, arthritis, insomnia, etc).

Current Prescription Medications (including hormones):

Medication Name and Strength	Date Started	How often per day

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List Hormones Previously Taken: Date Started Date Stopped Reason

_____

_____

_____

_____

Have you ever used oral contraceptives (birth control)? · Yes · No

If you experienced any problems, please describe: _____

_____

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

Any Interrupted pregnancies? · Yes · No

If yes, please explain:_____

Have you had a tubal ligation? · Yes · No If yes, date of surgery: _

Have you had a hysterectomy? · Yes · No If yes, date of surgery: _

Reason:_____Do your ovaries remain? · Yes · No

Do you have a family history of any cancers or osteoporosis? Please list the family member(s):

_____

_____

_____

Have you had any of the following tests performed?

Mammography	· Yes · No	Date:_____	Outcome:_____
PAP Smear	· Yes · No	Date:_____	Outcome:_____
Bone Density	· Yes · No	Date: _____	Outcome: _____

What age did your period start?_____ How many days is/was your cycle (Example: 28): _____

Any clots? · Yes · No

Is/was your menstrual flow heavy or light? _____

Have you ever had what YOU would consider to be abnormal cycles? · Yes · No

Explain: _____

_____

_____

When was your last period?_____ How many days did it last? _____

_____

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Do you or have you ever suffered from Premenstrual Syndrome (PMS) symptoms? · Yes · No

Explain: _____

_____

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Patient Name: _____

	Absent	Mild	Moderate	Severe
Hot Flashes				
Night Sweats				
Vaginal Dryness				
Incontinence				
Bleeding Changes				
Fibrocystic Breast				
Weight Gain				
Fluid Retention				
Dry Skin/Hair				
Hair Loss				
Anxiety				
Depression				
Mood Swings				
Irritability				
Headaches				
Breast Tenderness				
Cramps				
Difficulty Falling Asleep				
Difficulty Staying Asleep				
Fatigue				
Loss of Memory				
Foggy Thinking				
Acne				
Arthritis				
Decreased Sex Drive				
Harder to Reach Climax				
Stress				

Other: _____

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What are your goals for taking Hormone Replacement Therapy?

1.
2.
3.

Please list any other important information that you feel we should know about. In addition, please write down any questions you may have about Prescription Bio-Identical Hormone Replacement Therapy (Rx BHRT), or other medications.

1.

2.

3.

Doctor that we should contact for this therapy:

Name:_____ Phone: _____

Address: _____
Street City State Zip

*****Please include a copy of all relevant lab work, including your most recent hormone levels*****