



2121 Whitesburg Drive, Suite E ♦ Huntsville, Alabama 35801  
(256) 425-0123 ♦ Fax (256) 425-0195  
www.huntsvillecompounding.com

### MEDICAL HISTORY

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

SSN#: \_\_\_\_\_ RX Insurance: \_\_\_\_\_

Gender:  Male  Female ID: \_\_\_\_\_ GRP: \_\_\_\_\_

Cardholder: \_\_\_\_\_

How much and how often?

Do you use tobacco?  Yes  No  
Do you use alcohol?  Yes  No  
Do you use caffeine?  Yes  No

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

#### Allergies (Check all that apply):

penicillin  morphine  dye allergies  pet allergies  
 codeine  aspirin  nitrate allergy  seasonal (pollen) allergies  
 sulfa drug  food allergies  No Known Allergies  
 Other: \_\_\_\_\_

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

#### Over-the-Counter (OTC) Products:

Please check all products that you use occasionally or regularly. Check all that apply.

Pain Reliever  Combination Product (cough+cold reliever)  
 Aspirin  Sleep Aids (Excedrin PC®, Unisom®, Sominex®, Tylenol PM®)  
 Acetaminophen (Tylenol®)  Antidiarrheals (Imodium®, Pepto Bismol®, Kaopectate®)  
 Ibuprofen (Motrin®)  Laxatives/stool softeners (Doxidan®, Correctol®)  
 Naproxen (Aleve®)  Diet aids/weight loss products (Dexatril®)  
 Ketoprofen (Orudis KT®)  Antacids (Maalox®, Mylanta®)  
 Cough suppressant (Robitussin DM®)  Acid Blockers (Tagamet®, Pepcid AC®, Zantac®)  
 Antihistamine Product (Chlor-Trimeton®)  Decongestant Product (Sudafed®)  
 Other (Please Indicate) \_\_\_\_\_

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

- Vitamins (multiple or single vitamins such as B complex, E, C, beta carotene)
- Minerals (calcium, magnesium, chromium, iron, zinc, other)
- Herbs (Ginseng, Ginkgo Biloba, Echinacea, other herbal medicinal teas, tinctures, remedies, other)
- Enzymes (Digestive, papaya, bromelain, CoEnzyme Q10, other)
- Nutrition/Protein Supplements (shark cartilage, protein powders, amino acids, fish oils, other)
- Other \_\_\_\_\_

**Medical Conditions/Diseases.** Please check all that apply.

- Heart Disease (Congestive Heart Failure)
- High cholesterol or lipids (Hyperlipidemia)
- High blood pressure (Hypertension)
- Cancer: Tpye: \_\_\_\_\_
- Ulcers (stomach, esophagus)
- Thyroid disease/disorder
- Hormone Related Issues
- Lung condition (asthma, emphysema, COPD)
- Other: \_\_\_\_\_
- Blood clotting problems
- Diabetes
- Arthritis or joint problems
- Depression
- Epilepsy or seizure disorder
- Headaches/migraines
- Eye Disease (glaucoma, etc.)
- Liver disease

**Current Prescription Medications:**

Medication Name	Strength	Date Started	How often per day

**List Hormones Previously Taken:**

Medication Name	Strength	Date Started	How often per day

Have you ever used oral contraceptives?  No  Yes  
Any problems?  No  Yes  
If YES, please describe: \_\_\_\_\_

How many pregnancies have you had? \_\_\_\_\_ How many children? \_\_\_\_\_  
Any interrupted pregnancies?  No  Yes

Have you had a hysterectomy?  No  Yes (Date of Surgery) \_\_\_\_\_  
Have you had your ovaries removed?  No  Yes (Date of Surgery) \_\_\_\_\_  
Have you had a tubal ligation?  No  Yes (Date of Surgery) \_\_\_\_\_

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**Do you have a family history of any of the following?**

Uterine Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Family Member(s) _____
Ovarian Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Family Member(s) _____
Fibrocystic Breast	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Family Member(s) _____
Breast Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Family Member(s) _____
Heart Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Family Member(s) _____
Osteoporosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Family Member(s) _____

Have you had any of the following tests? Check those that apply and not the date of last test?

Mammography	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date: _____
PAP Smear	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date: _____

Since you began having periods, have you had what you would consider to be abnormal cycles?

No  Yes

If YES, please explain (such as age when the occurred, symptoms, etc.):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

When was your last period? \_\_\_\_\_

How many days did it last? \_\_\_\_\_

Do you have, or did you every have Prementrual 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?**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please write down any questions you have about BHRT.**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_



## Hormone Replacement Therapy Patient Information Sheet

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.

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

\_\_\_\_\_



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## **HUNTSVILLE COMPOUNDING PHARMACY**

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<http://www.huntsvillecompounding.com>  
e-mail: [info@huntsvillecompounding.com](mailto:info@huntsvillecompounding.com)

### **Service Fee Schedule**

**Initial Hormone Therapy Consultation**  
(Office or Telephone)

**\$75.00/Consultation**

## **Office Policy**

Payment is required at the time of provided service. Cash, personal check, money order, and Visa or Master Card are accepted.

If you must cancel an appointment, 24 hour notice is requested. In the event that we do not receive sufficient notice, you may be charged for the appointment. Adequate time is needed to notify other patients of openings.

I have received the fee schedule and office policy regarding payment for services and cancellation of appointments. I agree to be financially responsible for the costs of services.

Signature \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient)

PATIENT NAME: \_\_\_\_\_



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## WELCOME!

Thank you for your interest in Natural Hormone Replacement Therapy (NHRT). We look forward to working with you to achieve your goals, and we will work hard to help you reach them. In order to accomplish those goals, we feel it is important that our patients know us personally and have realistic expectations about NHRT.

## WHAT CAN I EXPECT?

- **We will work closely with your doctor** to find the right therapy to meet your needs. It is important for you, as the patient to communicate regularly with your physician about your goals. If your doctor needs more information about NHRT, we would be happy to provide it to him or her. The success of your therapy is greatly dependent upon a positive physician/patient/pharmacist relationship.
- **Every woman is different** and your therapy will be tailored specifically to your needs. Unlike the commercial hormone replacement therapies with only a few available strengths, with NHRT we can formulate any dosage in a variety of forms, according to your personal needs.
- **There will be an adjustment period** of approximately three months, though the time frame may vary slightly from one woman to the next. During this initial period, it is important for you to keep track of your symptoms with a daily chart, such as the one included in this packet. Your feedback is paramount in fulfilling your goals. Many symptoms may be related to hormone imbalance, and a list of several is included in this packet. Successful NHRT requires patience and consistent communication with your health care professionals.
- **We are here for your health**, and will be actively involved in helping you achieve your desired outcomes. Our pharmacists are available for personal counseling sessions, and are happy to make suggestions and address any questions and concerns that you may have.

### PRIVATE CONSULTATIONS

Our pharmacists are available for personal counseling sessions by appointment. This allows them one-on-one time with patients, free from interruption. Private consultations focus on all aspects of your health, including current medications and supplements, diet, lifestyle, and personal health history. Such detail will help our pharmacists to determine the best total therapy for you, and will give you a more in-depth understanding of your NHRT plan. The fee for a private consult is \$75 per half hour. Call for available appointment times.

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## What lab tests do I need to have prior to my consultation?

A saliva test or blood test can be done initially to determine if you have a hormonal imbalance. Once you get your results we can work with your prescriber and help develop an appropriate replacement program. Testing can also be done after you have been on hormone replacement to help further dial in your dosage. Saliva tests have achieved popularity because they are easily done at home (the saliva samples are sent by mail), and saliva tests measure “unbound” or “active” hormone levels. Saliva tests do not require a prescription. Blood tests are still popular with many prescribers.

More than 95% of blood hormones in women and men are bound to specific proteins, which carry them through the bloodstream. The other < 5% represents your free hormones - the free form of the hormone is physiologically active - meaning that it is readily available and can move throughout the body to perform its designated functions. Protein-bound hormones are not fully biologically active. It is the free portion of the hormone that affects the body and is the important value to pay attention to.

Common blood tests usually measure total hormone levels - which is the sum of the protein-bound portion plus the non-protein bound portion. These blood tests are unable to distinguish how much is free and available versus how much is bound and unavailable. Many times a patient is told they have a "normal" total hormone level, yet they are still exhibiting deficiency symptoms - which are most likely due to low free hormone levels.

Saliva testing is now being recognized as a reliable way to measure free hormone levels and test for hormone deficiencies. Saliva testing only measures unbound (free) hormone levels. Studies in the scientific literature have shown that there is a strong correlation between the levels of hormones found in saliva and the bioavailable levels of hormones in the bloodstream.

How often should I have my levels tested? Hormone levels should be assessed initially to establish baseline levels and determine a starting point for BHRT. If a patient wants to get started on BHRT right away, without any baseline levels, we suggest prescribing 3 months of therapy and then check saliva levels. Once a patient's regimen has been established, check levels yearly.

Hormones in saliva are very stable. Samples can be shipped to the testing facility by regular mail, without the need for special refrigeration. Saliva testing is a covered benefit by many insurance companies when ordered by a physician. If you have questions about insurance coverage - call the saliva lab directly. The cost is approximately \$40-50 per hormone level tested.

We will be happy to work with you whether you decide to have blood work or a saliva tests. We carry the saliva test kits at our store. It normally takes about 4 weeks to obtain the results from your saliva test.

### Specific Tests Needed:

<b>Sex Hormones: Saliva OR Blood Test</b>	<b>Thyroid Function: Blood Test ONLY</b>	<b>Adrenal Function: Saliva or Blood Test</b>
Estradiol, Estrone, Estriol Progesterone DHEA Testosterone	TSH, T4, Free T4, T3, Free T3, TPO, Reverse T3	Cortisol <ul style="list-style-type: none"> <li>If adrenal fatigue is suspected, a four point cortisol is recommended (AM, Noon, PM, Bedtime)</li> </ul>

PATIENT NAME: \_\_\_\_\_