InHealth SPECIALTY PHARMACY
"Individualized Medication Compounding"

2345 25th St. S. ● Fargo ND 58103
(701)365-6050 ● Toll free (866)365-6050
Fax: (701) 365-6051
pharmacy@inhealthrx.net
www.inhealthrx.net

Bio-Identical Hormone Replacement Therapy (BHRT)

- Services available through InHealth Specialty Pharmacy:
  - Regular seminars about the full range of peri/menopausal health are conducted every Tuesday 12pm-1pm to educate area women. Reservations required.
  - Consultations regarding BHRT. Appropriate levels should be available at the time of consultation. We will then make recommendations to your provider as to dosage and dosage forms. (Cost is $150 for one hour. For patients with extensive and complicated medical history, the consultation process may require additional time. Provider will notify you in advance. For each additional 30 minutes, the cost is $75. For a single hormone consult, the fee is $75.
  - Extensive follow-up for each patient to fine-tune dosages.

- We have copies for sale of some of the most popular books about peri/menopause and sexual dysfunction
- The hormones used in our compounds are exact molecular duplicates of human hormones.
- Dosages can be formulated for the individual.
- A full range of menopausal symptoms can be treated with BHRT.
  - Conservative use: lowest effective dose, shortest duration *(consistent with the recommendations of the North American Menopause Society)*
- Major difference from conventional HRT is that bio-identical progesterone is often used (effectively) ALONE and should ALWAYS be given when estrogen is used systemically.
- Compounds can be prepared using the three estrogens (seldom use estrone any longer), progesterone, testosterone, and DHEA.
- Compounded formulas are usually made up of a majority of estriol (weakest of the three estrogens) and small amounts of estradiol when estrogen therapy is indicated.
  - *Scientific literature suggests that there is a link between estrogen use and breast cancer*.
- Androgen supplementation is available using testosterone in several formulations, also DHEA.

I have read the above information on compounded BHRT.

Today's Date: _____
Name Printed: _____
Date of Birth: _____
Phone Number: (H)_____ (W)_____ (C)_____

Signature: _____

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Medical History

Today's Date: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (H) _____ (W) _____ (C) _____

Email: _____

Gender: □ Female □ Male Height: _____ Weight: _____

			How often and how much?
Do you use tobacco?	□ Yes	□ No	_____
Do you use alcohol?	□ Yes	□ No	_____
Do you use caffeine?	□ Yes	□ No	_____

Doctor's Name: **Clinic Name:**

_____

_____

_____

Allergies: (Please check all that apply)

□ Penicillin	□ Morphine	□ Dye allergies	□ Pet allergies
□ Codeine	□ Aspirin	□ Nitrate allergy	□ Seasonal (pollen)
□ Sulfa drugs	□ Food allergies	□ Lactose	□ No known allergies

□ Other (please list): _____

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

_____

_____

Over-the-counter (OTC) issues:

Please check all products that you use regularly. (Please check all that apply)

□ Pain reliever	□ Aspirin	□ Acetaminophen
□ Ibuprofen	□ Naproxen	□ Ketoprofen
□ Cough Suppressant	□ Antihistamine	□ Decongestant
□ Sleep Aids	□ Antidiarrheals	□ Laxative/Stool softner
□ Diet aids/weight loss	□ Antacids	□ Acid blockers

□ Other (please list): _____

Nutritional/Natural Supplements: Please list the products you are taking and if possible give a photocopy of the ingredients on the label.

_____

_____

_____

_____

_____

Medical Conditions/Diseases: (Please check all that apply)

□ Heart disease	□ High cholesterol	□ High blood pressure
□ Cancer	□ Ulcers	□ Thyroid disease
□ Lung conditions	□ Blood clotting problems	□ Diabetes
□ Depression	□ Arthritis or joint problems	□ Epilepsy
□ Headaches/migraines	□ Eye disease (glaucoma etc)	□ Other: (Please list)

_____

_____

Have you ever been told by a healthcare provider that you should not receive hormone therapy (e.g., estrogen, progesterone)? Yes or No (Please circle)

If Yes, please explain: _____

_____

_____

_____

_____

Current Prescription Medications:

Medication Name Strength Date Started How often per day

_____

_____

_____

_____

_____

List Hormones previously taken Date Started Date Stopped Reason

_____

_____

_____

_____

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 of surgery _____

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 date of last test.

Mammography □ No □ Yes Date: _____

PAP Smear □ No □ Yes Date: _____

Thyroid Tests

TSH Level: _____ Date: _____

T4 Level: _____ Date: _____

T3 Level: _____ 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 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 you goals with taking BHRT?

_____

_____

_____

Please write down any questions you have about BHRT:

_____

_____

SOCIAL HISTORY

What is your current occupation or your occupation prior to retirement?

_____

Describe your work or volunteer environment?

_____

How many hours a week do you work or volunteer?_____

Are you satisfied with your work or volunteer situation? _____

_____

Do your symptoms differ at work and at home?_____

_____

Do you have trouble getting out of bed in the morning or feel fatigued during the day?

_____

_____

Who lives in your household? _____

_____

Describe your living environment? _____

_____

How many hours of sleep do you get a night? _____

How would you describe the quality of sleep you get? _____

_____

How often do you eat out? _____

How would you describe your diet? _____

_____

Do you have an exercise routine? _____

What does it consist of? _____

RATING OF SYMPTOMS

Please indicate the symptoms you are experiencing as **0 None, 1 Mild, 2 Moderate, 3 Severe**

0	1	2	3	Hot Flashes	0	1	2	3	Dizzy Spells
0	1	2	3	Night Sweats	0	1	2	3	Cold Body Temperature
0	1	2	3	Incontinence	0	1	2	3	Goiter
0	1	2	3	Bleeding Changes	0	1	2	3	Hoarseness
0	1	2	3	Uterine Fibroids	0	1	2	3	Hair Dry or Brittle
0	1	2	3	Water Retention	0	1	2	3	Nails Breaking or Brittle
0	1	2	3	Tender Breasts	0	1	2	3	Constipation
0	1	2	3	Fibrocystic Breasts	0	1	2	3	Slow Pulse Rate
0	1	2	3	Increased Forgetfulness	0	1	2	3	Rapid Heartbeat
0	1	2	3	Foggy Thinking	0	1	2	3	Heart Palpitations
0	1	2	3	Tearful	0	1	2	3	Infertility Problems
0	1	2	3	Depressed	0	1	2	3	Acne
0	1	2	3	Mood Swings	0	1	2	3	Increased Facial/Body Hair
0	1	2	3	Stress	0	1	2	3	Scalp Hair Loss
0	1	2	3	Morning Fatigue	0	1	2	3	Weight Gain-Hips
0	1	2	3	Evening Fatigue	0	1	2	3	Weight Gain-Waist
0	1	2	3	Difficulty Sleeping	0	1	2	3	High Cholesterol
0	1	2	3	Decreased Stamina	0	1	2	3	Elevated Triglycerides
0	1	2	3	Anxious	0	1	2	3	Decreased Libido
0	1	2	3	Irritable	0	1	2	3	Decreased Muscle Size
0	1	2	3	Nervous	0	1	2	3	Thinning Skin
0	1	2	3	Fibromyalgia	0	1	2	3	Ringing in Ears
0	1	2	3	Allergies	0	1	2	3	Rapid Aging
0	1	2	3	Headaches	0	1	2	3	Aches and Pains
0	1	2	3	Sugar Cravings	0	1	2	3	Bone Loss
0	1	2	3	Painful Intercourse	0	1	2	3	Vaginal dryness/Atrophy

Total Symptom Score:

_____