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
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Women's Hormone and Wellness Consultation

- Services available through InHealth Specialty Pharmacy:
  - Women's Hormone and Wellness Consultation includes an initial consultation that covers hormones, sleep, fitness, and nutrition (lasts about 45 min), and also a follow-up consultation focused on customized hormone replacement (lasts about 30 min) - $250 (Includes both consultations).
  - Optional yearly follow-up consultation (lasts about 30 min) - $100.
- The hormones used in our compounds are considered bio-identical, and are exact molecular duplicates of human hormones.
- Dosages can be formulated for the individual.
- A full range of menopausal symptoms can be treated with bio-identical hormone replacement therapy (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.
  - *NOTE: Scientific literature suggests that there is a link between estrogen replacement and breast cancer, stroke, or coronary heart disease. Each patient should be individually assessed for potential risk.*

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:

_____