



York-Davis Pharmacy  
 679 Davis Drive.  
 Newmarket, Ontario L3Y 5G8  
 Toll-free: 1-888-592-3302  
 Fax: 905-898-7225

Date: \_\_\_\_\_

## HORMONE EVALUATION FORM

All questions contained in this questionnaire are strictly confidential  
 and will become part of your medical record.

PATIENT INFORMATION			
<b>Name</b> <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M	<input type="checkbox"/> F	<b>DOB:</b>
<b>Age:</b>			
<b>Marital status:</b>	<input type="checkbox"/> Single	<input type="checkbox"/> Partnered	<input type="checkbox"/> Married
	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
<b>Address:</b>	<b>City:</b>	<b>Province:</b>	<b>Postal Code:</b>
<b>Phone Number:</b>	<b>E-mail Address:</b>		
<b>Family Doctor</b>			
Name:	Address:	Phone Number:	

MEDICATIONS AND ALLERGIES
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**List your prescribed drugs, over-the-counter drugs, such as vitamins and inhalers and any natural supplements you take regularly or occasionally (or attach a list from your pharmacist).**

Name the Drug	Strength	How many times per day?	Reason for taking it?

**List any hormone therapy you have taken recently (for replacement, symptom management, etc.)**

Name and Strength	Date Started	Date stopped (if applicable)	Reason for starting/stopping it?

**Allergies**

Please check any allergies you may have:	<input type="checkbox"/> Medications <input type="checkbox"/> Food <input type="checkbox"/> Seasonal <input type="checkbox"/> Pets <input type="checkbox"/> Gluten <input type="checkbox"/> Lactose <input type="checkbox"/> None Known
<b>Name the Drug</b>	<b>Reaction You Had</b>

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**HEALTH HABITS**

<b>Exercise</b>	<input type="checkbox"/> Sedentary (No exercise)				
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
<b>Caffeine</b>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola	
	# of cups/cans per day?				
<b>Alcohol</b>	Do you drink alcohol?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind?				
	How many drinks per week?				
<b>Tobacco</b>	Do you use or have you ever used tobacco?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day	
	<input type="checkbox"/> # of years	<input type="checkbox"/> quit date (if applicable)			
<b>Drugs</b>	Do you currently use recreational or street drugs?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Sex</b>	Are you sexually active?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever used oral contraceptives?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever had any problems from the contraceptives?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If YES, describe problem(s):				
	Any discomfort with intercourse?			<input type="checkbox"/> Yes	<input type="checkbox"/> No

**FAMILY HEALTH HISTORY**

Do you have any family history of any of the following (check all that apply):

<input type="checkbox"/> Uterine Cancer	Family Member(s) _____	<input type="checkbox"/> Breast Cancer	Family Member(s) _____
<input type="checkbox"/> Ovarian Cancer	Family Member(s) _____	<input type="checkbox"/> Heart Disease	Family Member(s) _____
<input type="checkbox"/> Fibrocystic Breast	Family Member(s) _____	<input type="checkbox"/> Osteoporosis	Family Member(s) _____

	AGE	SIGNIFICANT HEALTH PROBLEMS	AGE	SIGNIFICANT HEALTH PROBLEMS
<b>Father</b>			<b>Children</b>	<input type="checkbox"/> M <input type="checkbox"/> F
<b>Mother</b>				<input type="checkbox"/> M <input type="checkbox"/> F
<b>Siblings</b>	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandmother Maternal</b>	
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandfather Maternal</b>	
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandmother Paternal</b>	
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandfather Paternal</b>	

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**PERSONAL HEALTH HISTORY**

**List any medical problems that other doctors have diagnosed**

Please check all that apply to you

<input type="checkbox"/> Heart Disease <input type="checkbox"/> Blood Clotting Problems <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes      If yes: <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Depression <input type="checkbox"/> Mental Illness <input type="checkbox"/> Epilepsy <input type="checkbox"/> Headaches / Migraines <input type="checkbox"/> Hormonal Related Issues <input type="checkbox"/> Cancer (Please specify below)	<input type="checkbox"/> Ulcers (example: stomach, esophagus) <input type="checkbox"/> Arthritis or Joint Problems <input type="checkbox"/> Eye Disease (example: Glaucoma, etc.) <input type="checkbox"/> Lung Condition (e.g. asthma, COPD) <input type="checkbox"/> Other (Please specify below)
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Please provide the requested detail(s):


**Surgeries**

Have you ever had any of the following surgeries? If yes, please specify details below.

Hysterectomy (uterus removed)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Oophorectomy or ovariectomy (ovaries removed)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tubal ligation ("tubes tied")	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dilation & Curettage ("D&C", scraping of the uterus)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Caesarean (C-section)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you answered yes to any of the above, or had other surgeries not mentioned above, please specify below:

Year	Reason	Hospital

**Other Tests and Investigations**

Have you had any of the following tests performed?

Mammography If yes, date of last test: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
PAP Smear If yes, date of last test: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rectal exam If yes, date of last test: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Other tests and/or investigations:

Test/Investigation	Date	Reason



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**PERSONAL HEALTH HISTORY (CONTINUED)**

Age at onset of menstruation:		
Date of last menstruation:		
How many days did it last? _____ days		
Since you first began having periods, have you ever had what YOU would consider to be abnormal cycles?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please describe (e.g. heavy periods, irregularity, spotting, pain, or discharge)		
Do you have, or did you ever have Premenstrual Syndrome (PMS)? If yes, please describe symptoms (e.g. menstrual tension, pain, bloating, irritability, or other symptoms):	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**FOR MEN ONLY**

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times _____		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No



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### SYMPTOM QUESTIONNAIRE

Please place a check mark (✓) next to each of the following symptoms to rank its severity from absent (not experienced at all) to severe (frequently experienced and/or bothersome).

Symptom	Absent	Mild	Moderate	Severe
Fibrocystic Breast				
Uterine Fibroids				
Bone Loss				
Hot Flashes				
Night Sweats				
Breast Tenderness				
Cramps				
Fluid Retention				
Breakthrough Bleeding				
Heavy / Irregular or Changes in Bleeding				
Vaginal Dryness				
Anxiety / Nervous				
Depression				
Tearful				
Irritability				
Mood Swings				
Headaches				
Aches & Pains				
Memory Loss / Lapses				
Foggy Thinking				
Dry Skin / Hair				
Thinning Skin				
Bone Loss				
Dry Brittle Nails				
Acne				
Hair Loss				
Increased Urinary Urge				
Urinary Leakage / Incontinence				
Harder to Reach Orgasm				
Decreased Sex Drive				
Decreased Muscle Size				
Increased Facial or Body Hair				
Rapid Aging				
Insomnia				



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**SYMPTOM QUESTIONNAIRE (CONTINUED)**

Symptom	Absent	Mild	Moderate	Severe
Interrupted Sleep				
Difficult falling asleep				
Difficult waking up				
Evening Fatigue				
Morning Fatigue				
Decreased Stamina				
Stress				
Weight Gain: Hips				
Weight Gain: Waist				
Infertility Problems				
Allergies				
Sugar Cravings				
Low Blood Sugar				
High Cholesterol				
Elevated Triglycerides				
High Blood Pressure				
Low Blood Pressure				
Slow Pulse Rate				
Rapid Heartbeat				
Heart Palpitations				
Swelling or Puffy Eyes / Face				
Numbness - Feet / Hands				
Cold Body Temperature				
Goiter				
Constipation				
Hoarseness				
Hearing Loss				
Decreased Sweating				

**FINAL THOUGHTS ON BIO-IDENTICAL HORMONE REPLACEMENT THERAPY**

How did you arrive at the decision to consider Bio-Identical (Natural) Hormone Replacement Therapy?  
 Doctor  Self  Friend or Family Member  Other: \_\_\_\_\_

What are your goals with taking Bio-Identical Hormone Replacement Therapy?

Please write down any questions you have about Bio-Identical Hormone Replacement Therapy