



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: _____



"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

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)

- | | | |
|---|---|---|
| <input type="checkbox"/> Pain reliever | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Acetaminophen |
| <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Naproxen | <input type="checkbox"/> Ketoprofen |
| <input type="checkbox"/> Cough Suppressant | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Decongestant |
| <input type="checkbox"/> Sleep Aids | <input type="checkbox"/> Antidiarrheals | <input type="checkbox"/> Laxative/Stool softner |
| <input type="checkbox"/> Diet aids/weight loss | <input type="checkbox"/> Antacids | <input type="checkbox"/> Acid blockers |
| <input type="checkbox"/> 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)

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Lung conditions | <input type="checkbox"/> Blood clotting problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Arthritis or joint problems | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Headaches/migraines | <input type="checkbox"/> Eye disease (glaucoma etc) | <input type="checkbox"/> 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:
