Boone Drug, Inc.

Consultation Date:_____/_____/_____

579 Greenway Road
Boone, NC 28607
Phone: 828-355-3350 / FAX: 828-264-8368

Referring Provider (MD, PA, CNM,etc.)_____

Other Healthcare Providers: _____

General Information

Last Name _____First Name: _____Middle Initial ____

Preferred first name: _____ Address: _____ City_____

State _____ZIP: _____ Age: _____ Birth Date: ____/_____/_____

E-mail: _____ Preferred Contact Phone number: (___) _____-

Occupation: _____ Full-Time____ Part-Time____ Retired____ Unemployed____

Living Situation: Significant Other(s)_____ Alone _____

How did you hear about Bio-Identical Hormone Replacement Therapy? (please √ all that apply)

Another Patient_____ Healthcare Practitioner _____ Newspaper Ad _____ Other: _____

What are your hobbies? _____

Do you have questions about what Bio-Identical Hormone Replacement Therapy is? YES / NO

Medical History

General Health: Excellent__ Good___ Fair___ Poor___ Weight: _____ Height: _____ Measurable Height Loss: **Y / N**

Drug Allergies: _____

Allergies to food, pollens, etc.: _____

Current Medications: _____

_____

Current Vitamins/ Herbs/OTC products: _____

_____

Please check (√) any of the listed **medical problems** you have:

Heart Trouble_____ High Blood Pressure_____ Varicose Veins_____ Blood Clots_____ Kidney Trouble_____

Diabetes_____ Bone Loss_____ Arthritis_____ Fibromyalgia_____ Colitis_____ Cancer_____ Asthma_____

Diarrhea_____ Chronic Fatigue_____ Reflux (GERD)_____ Eating Disorder_____ Constipation_____

Urinary Incontinence_____ Restless Legs_____ Thyroid Trouble____ Brittle Nails _____ Cold Hands/Feet _____

Excessive Gas _____ Cholesterol _____ MS _____

Other diagnoses:

_____

Please list any **surgeries** you have had: _____

Are you feeling well? YES / NO How long has it been since you did feel well? _____

Do you **FEEL** Older/Younger/the Same as your age? **Stress Level**: absent_____ mild _____ moderate_____ severe_____

Last **mammogram**: Date: _____ Normal: YES / NO **Bone Density Scan** Date: _____ Normal: YES / NO

Habits

Dietary Restrictions: _____

Do you get physical exercise? _____ What type and how often? _____

_____

Do you use tobacco products? _____ How long: _____

Do you use alcohol products? Yes / No If yes: occasional, social, or otherwise?

Do you use caffeine products? _____ How much: _____

Family History

What age was your mother at her onset of menopause? _____ Symptoms? _____

How many siblings? (brothers____ sisters____) Age of sisters at time of their onset of menopause? _____

Symptoms? _____

Do you have a family history of any cancers or osteoporosis? Please list the family member(s):

Gynecological History

Age at first period: _____ Date of last period: ___/____/_____

Age at first pregnancy: _____ How many full-term pregnancies? _____ Problems: _____

Any interrupted pregnancies? (miscarriages, terminated pregnancies): **Y / N** How many?____

Have you had a tubal ligation (tubes tied): **Y / N** What year? ____ Have you had a hysterectomy? **Y / N** What year? ___

Why?

Do one or both of your ovaries remain? **One/Both/None** What year was the removal?_____Why?_____

Date of last pelvic exam: ____/_____/_____Last Pap smear: ____/____/____ Normal: Y / N

Have you ever had an abnormal pap? Y / N Treatment?_____

Are you sexually active? **Y / N** Are you trying to get pregnant? **Y / N** Current birth control method: _____How long?_____

Problem with it: Y / N Past birth control methods and any related problems: _____

IF you are having periods:

Amount of: **Bleeding:** Light___Mod. ___Heavy___**Cramps:** Mild___Mod. _____Severe___**Clots: Y / N**

How many days from start of one period to start of the next? _____ Number of days of flow: _____

List PMS symptoms:

Changes noted in your normal cycle?

Any bleeding between periods: **Y / N** Any pelvic pain, pressure or fullness: **Y / N**

Any vaginal discharge or itching: **Y / N** Describe:_____ Treatment:

If you are NOT having periods:

What treatments have you previously tried to alleviate menopausal symptoms?

I have read and understand Boone Drug's BHRT policy. (Please sign and date).

_____ (sign) _____ (date)