jayhawk pharmacy
& patient supply

Bio-Identical Hormone Replacement Therapy Assessment and Evaluation Checklist

These items must be completed and on file with the pharmacy prior to your evaluation:

-Pharmacy Record Release Authorization Form

-Confidential Personal Medical History Form

-Hormone Replacement Therapy Patient Information Sheet

-Question Documentation Form (any questions you might have for our pharmacist)

-Provide copies of any relevant blood and/or saliva tests results if available (ie. estradiol, estriol, estrone, progesterone, testosterone, cortisol, etc.)

-Return all materials to the pharmacy (by mail or in-person) prior to scheduling your 1-hour consultation with our pharmacist, **Mike Conlin RPh., F.I.A.C.P., F.A.C.A**

Jayhawk Custom Pharmacy
6730 SW. 29th St. Ste. C
Topeka, KS 66614
Phone: (785)-228-9740 Fax: (785) 228-9745

IACP™ INTERNATIONAL ACADEMY OF COMPOUNDING PHARMACISTS MEMBER

PCCA

AMERICAN COLLEGE APOTHECARIES

Pharmacy Record Release Authorization

I, the undersigned patient authorize my pharmacist to release and/or request my personal medication and/or other medical information to/from the following physicians or medical organizations upon request or as deemed necessary:

Physician Name	Office Address	Telephone
1)		
2)		
3)		

Patient Name: _____

Address: _____

City, State, Zip _____

Phone: _____

Signature: _____

Date: _____

Jayhawk Custom Pharmacy

Bioidentical Hormone Replacement Questionaire

NAME OF PATIENT: _____ DATE OF BIRTH: ___/____/_____

ADDRESS: _____ CITY:_____ ZIP: _____ STATE: _____

HOME PHONE: (_____) _____ WORK: (_____) _____ CELL: (_____) _____

E-MAIL: _____ SOCIAL SECURITY/DRIVERS LICENSE NUMBER: _____

HEIGHT: _____ WEIGHT: _____ HOW FAR FROM PERSONAL GOAL WEIGHT? _____

MEDICAL CONTACT

PHYSICIAN NAME: _____ PHYSICIAN PHONE: (_____) _____

DATE OF LAST PHYSICAL EXAMINATION: _____ RESULTS: _____

Have you discussed your hormone replacement therapy goals with your provider? If YES, please explain:

_____

What were their comments and recommendations? _____

Do you have any concerns with hormone replacement therapy? _____

PERSONAL OVERVIEW

Are your still menstruating? YES NO

Date of last menstrual period _____

How regular are your menstrual periods? _____

Do you still have your ovaries? YES NO

Do you still have your uterus? YES NO DATE OF SURGERY: _____ REASON: _____

How many pregnancies have you experienced? _____

How many children have you had? _____

At what age did your mother reach menopause? _____

At what age did your sisters reach menopause? _____

Discuss any allergies you have:

Foods: _____

Medications: _____

Other: _____

Are you lactose intolerant? YES NO

PREVIOUS EXPERIENCE WITH HRT THERAPY

Discuss any <u>previous</u> Hormone Replacement Therapy:

START DATE: _____ What did you try? _____

What did you like? _____

What did you dislike? _____

Reasons for discontinuing: _____

Discuss any <u>current</u> Hormone Replacement Therapy:

START DATE: _____ What are you using? _____

What do you like? _____

What do you dislike? _____

PERSONAL MEDICAL HISTORY

Please indicate any previous or current medical conditions and the date of diagnosis:

YES	NO	MEDICAL CONDITION	DATE OF DIAGNOSIS
		Angina/ Chest Pain	
		Anxiety	
		Blood Clot	
		Bone Fracture	
		Cancer	
		Depression	
		Endometriosis	
		Fibrocystic Breast Disease	
		Heart Attack	
		Heart Disease	
		High Blood Pressure	
		Lupus	
		Migraine	
		Obesity	
		Rheumatoid Arthritis	
		Osteoporosis	
		Prematurely Gray	
		Sleep Apnea	
		Other	

FAMILY MEDICAL HISTORY

Please indicate any previous or current medical condition and the relationship to the person:

YES	NO	MEDICAL CONDITION	RELATIONSHIP
		Angina/ Chest Pain	
		Anxiety	
		Blood Clot	
		Bone Fracture	
		Cancer	
		Depression	
		Endometriosis	
		Fibrocystic Breast Disease	
		Heart Attack	
		Heart Disease	
		High Blood Pressure	
		Lupus	
		Migraine	
		Obesity	
		Rheumatoid Arthritis	
		Osteoporosis	
		Prematurely Gray	
		Sleep Apnea	
		Other	

PERSONAL MENSTRUAL OVERVIEW

ADOLESCENCE

Age at which menstrual period began: _____

How would you describe your menstrual cycle?

YES	
	Light
	Moderate
	Heavy
	Unbearable

How would you describe your physical or emotional condition one week before your menstrual cycle?

_____

ADULTHOOD

How would you describe your menstrual cycle?

YES	
	Light
	Moderate
	Heavy
	Unbearable

How would you describe your physical or emotional condition one week before your menstrual cycle?

_____

If you currently have your menstrual cycle, is it the same as listed above? YES NO

Are you currently sexually active? YES NO

Are you satisfied with your current sexual activity? YES NO

What would you like to change about your sexual activity? _____

Have you previously taken oral contraceptives? YES NO

Name: _____

How long: _____

Issues with use: _____

CURRENT PRESCRIPTION MEDICATIONS

Medication	Reason	Duration of Treatment	Prescribing Physician

CURRENT NON-PRESCRIPTION MEDICATIONS

Medication	Reason	Duration of Treatment	Prescribing Physician

CURRENT VITAMIN/ MINERAL/ HERBAL SUPPLEMENTS AND MEDICATIONS

Medication	Reason	Duration of Treatment	Prescribing Physician

PERSONAL SLEEP HABITS

Please indicate any of the following symptoms that describe your sleep habits:

SLEEP HABITS	YES	NO	FREQUENCY
Snore, gasp, stop breathing			
Fight off sleep while driving			
Fight off sleep while reading			
Fight off sleep while watching TV			
Fight off sleep while working			
Have trouble falling asleep			
Have trouble staying asleep			
Wake up and cannot fall back asleep			
Experience daytime fatigue			
Does your bed partner complain of your snoring?			

Have you been diagnosed with sleep apnea? YES NO

When were you diagnosed? _____

Is it currently treated? YES NO How? _____ How often? _____

How many hours do you sleep per night? _____

PERSONAL LIFESTYLE CONSIDERATIONS

Please list current major stressors/ obstacles to daily living:

_____

_____

Describe how you spend your leisure time:

_____

_____

Describe your exercise activities:

_____

_____

How healthy would you describe your daily diet?

_____

_____

PERSONAL DIET CONSIDERATIONS

How often do you consume the following items?

	DAILY	WEEKLY	MONTHLY	NEVER
Alcohol				
Caffeine				
Spicy Foods				
Tobacco				

List your food intake for the last three days:

BREAKFAST LUNCH DINNER SNACK

1 _____

2_____

3_____

PERSONAL SYMPTOM SURVEY

Please rate from 1 (never) to 5 (most severe) the following symptoms:

Symptom	1	2	3	4	5	How Frequent?
Anxiety						
Bloating						
Depression						
Fuzzy Thinking						
Headache						
Incontinence						
Low sex drive						
Moodiness						
Swollen Breasts						
Cramps						
Emotional Swings						
Painful Breasts						
Early Menstruation						

Symptom	1	2	3	4	5	How Frequent?
Headache						
Heart Palpitations						
Hot Flashes						
Insomnia / Sleep Disturbances						
Night Sweats						
Painful Intercourse						
Shortness of Breath						
Short Term Memory Loss						
Tearfulness						
Vaginal Dryness						
Dry Skin						
Inability to Reach Orgasm						
Lack of Menstruation						

Symptom	1	2	3	4	5	How Frequent?
Breast Swelling						
Cold Hands/ Feet						
Cravings for Sweets						
Fatigue						
Fibrocystic Breasts						
Water Retention						
Weight Gain						

PERSONAL SYMPTOM SURVEY (CONTINUED)

Please list any other bothersome symptoms that you would like to fix:

_____

_____

_____

Which three symptoms would you like to fix as soon as possible?

_____

_____

_____

What are your personal goals with taking BHRT?

_____

_____

_____

What is the best way for us to contact you? (Phone, email, etc…)

_____

May we send you information via email? YES NO

May we leave you a voice mail? YES NO

Patient Signature: _____ Date: _____

Patient Print: _____

Question Documentation Form

Please write down any questions you may have about Prescription Bio-Identical Hormone Replacement Therapy (Rx BHRT), other medications, or any other questions that come up as you read through the materials you have received. Bring this question sheet with you to your consultation so you can discuss this information with your pharmacist. Thank you.

1.

2.

3.

4.

5.

Frequently Asked Questions

Q. When will I be contacted after submitting all of the materials?

A. It is not uncommon to wait two (2) weeks before receiving initial therapy recommendations. At the time Jayhawk pharmacy receives the materials and assessment and evaluation are performed. You will be contacted with any questions. A formal assessment and plan with therapy recommendations is sent to your doctor. Once authorization from your doctor is received you will be contacted about your treatment regimen.

Q. After my initial treatment regimen how am I monitored?

A. Our staff is always available for questions during normal business hours. Follow up will be done at 3 days, 21 days, and 50 days from the time you initiate your treatment regimen. Monitoring from that point on will be annual or as needed.

Q. How long before I notice symptomatic relief?

A. Symptomatic relief varies depending on the symptom and specific hormone regimen; anywhere from a few days to several weeks in certain situations.

Q. Are there any side effects?

A. As with any medication there is always a possibility of side effects. We will consult you on these possibilities and how to remedy them.

Q. What dosage forms do you provide?

A. Bio-Identical hormones are most commonly compounded into capsules, creams, and oral lozenges. Working with your physician, we will determine the most appropriate and convenient dosage form for you.

Q. Is the assessment and evaluation fee covered by my insurance?

A. No. The cost of the 1-hour consultation appointment is $150. This covers the cost of the appointment, as well as the time necessary to evaluate/formulate a BHRT regimen, in addition to our follow up consultations with you.

Q. Are the prescriptions covered by my insurance?

A. Many are but, depending on the insurance and specific hormone prescribed, individual coverage benefits may vary. We always provide a Universal Claim Form to submit to your insurance provider. All patients pay up front for their medications. However, all of the medications that we compound have a National Drug Code (NDC). It is necessary to consult with your insurance prior to picking up your prescriptions to determine coverage of your medication.

Q. Do I need blood or saliva tests?

A. No, we take any lab work into consideration if available. If not, treatment recommendations are made based on the clinical picture, including, but not limited to: family history, past medical history, and symptoms.