jayhawk pharmacy
& patient supply

Bio-Identical Hormone Replacement Therapy (BHRT) 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 (i.e. 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
2860 SW Mission Woods Dr., Ste A2
Topeka, KS 66614
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IACP™
INTERNATIONAL ACADEMY OF COMPOUNDING PHARMACISTS
MEMBER

PCCA

Pharmacy Record Release Authorization

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

Physician Name	Office Address	Telephone
1)		
2)		
3)		

Patient Name: _____

Address: _____

City, State, Zip _____

Phone: _____

Signature: _____

Date: _____

BIOIDENTICAL HORMONE REPLACEMENT THERAPY QUESTIONNAIRE

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

ADDRESS _____ **CITY**_____ **ZIP** _____**COUNTY**_____

HOME PHONE (___)_____ **WORK** (___)_____ **CELL** (___)_____

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

HEIGHT _____ **WEIGHT** _____ **How far from personal goal weight?** _____

MEDICAL CONTACT

PRIMARY PHYSICIAN_____

PHYSICIAN_____ (ordering for you today if different)

LAST PHYSICAL EXAMINATION_____**RESULTS**_____

Have you discussed your hormone replacement goals with your primary care provider?

_____

What were their comments and recommendations? _____

What are your 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 of the therapy_____ **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	

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

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

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 is?

_____

_____

PERSONAL DIET CONSIDERATIONS

How often do you consume the following items?

	DAILY	WEEKLY	MONTHLY	NEVER
Alcohol				
Caffeine				
Spicy Foods				
Tobacco				

List the past 3 day's food intake:

BREAKFAST LUNCH DINNER SNACK

1 _____

2 _____

3 _____

SYMPTOM SURVEY

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

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

Please list any other bothersome symptoms which 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?

_____

May we send you information via email? YES NO

May we leave you a voice mail? YES NO

Signature: _____ **Date:** _____

Print: _____

Question Documentation Form

Please write down any questions you may have about prescription Bio-Identical Hormone Replacement Therapy (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. At Jayhawk we make every effort to expedite the evaluation process, but it is not uncommon to wait two (2) weeks before your questionnaire is thoroughly evaluated by our BHRT specialists. Once this is completed, we will contact you to schedule your in-person consultation. After the consultation, a formal assessment and plan with therapy recommendations will be sent to your doctor. Once authorization from your doctor is received, you will be contacted about your recommended treatment regimen and your custom prescriptions will be compounded here in our lab.

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

A. Our staff is always available for questions during normal business hours via phone call or email. During the initial weeks and months of therapy, feedback and communication is encouraged and frequent. 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 $100. 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. Depending on your individual insurance plan, coverage will vary. All patients pay up front for their medications, and we always provide a Universal Claim Form with your prescriptions that you may submit to your insurance provider. Your insurance provider will then reimburse you if any or all of your medication is covered.

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.