Health Assessment Form (Please fill out this as accurately as possible so we can find the best solution for you. A team member will be in touch shortly.)

Full Name (required):______________________________ Date: ______________

Email (required) ______________________________ DOB (required)______________

We will need valid identification before issuing any scripted medications.
Please scan ie drivers license or passport and upload/fax with this document:

Phone (required):______________ Email (required: ______________________________

Address: ______________________________________________________________

City:______________ State:______________ Postcode: ______________

Please list your current medications (type 'none' otherwise)

______________________________________________________________

Please list your medical conditions (type 'none' otherwise)

______________________________________________________________

Please list your current supplements you are taking including vitamins, minerals and/or herbal formulas. (type 'none' otherwise)

______________________________________________________________

Known Allergies (including antibiotics, drug, food, pollen)

______________________________________________________________

| **Family History** | **(relationship)** |
| --- | --- |
| Cancer (type) | ______________ |
| Heart Condition | ______________ |
| Diabetes | ______________ |
| High Blood Pressure | ______________ |
| Osteoporosis | ______________ |
| Family History of significant conditions | ______________ |
| Other | ______________ |

Notes and/or Questions:

______________________________________________________________

______________________________________________________________

______________________________________________________________

**What compounds/product(s) are you interested in?**

______________________________________________________________

**What is/are your desired outcome(s)?**

______________________________________________________________

## Section 2. ***WOMEN ONLY***For Bioidentical Hormone Replacement

### Personal History

- ☐ Blood Clots
- ☐ Uterine Fibroids
- ☐ Smoking History
- ☐ Impaired Liver Function
- ☐ Endometriosis
- ☐ Diabetes
- ☐ Fibrocystic Breasts
- ☐ Abnormal Vaginal Bleeding
- ☐ Stroke
- ☐ Thrombophlebitis
- ☐ Cancer (type)________________
- ☐ High Blood Pressure
- ☐ Ovarian Cysts
- ☐ PCOS
- ☐ Other _________________
- ☐ Other _________________
- ☐ Heart Disease
- ☐ Osteoporosis

Cholesterol Serum:_______Date:_________ Triglycerides:____ HDL:____ LDL:____ Chol/HDL Ratio:_____

Bone density scan results:___________Date: _________

Current Health Care Provider/s:______________________________________________________________________

Prior Hormone Replacement Therapy History: (include dates of use) _______________________________________

_____________________________________________________________________________________________

Are you currently following a special diet (Gluten Free, Casien Free, Arkins, Paleo, etc):______________________

_____________________________________________________________________________________________

Do you eat/drink soy:___________Caffeine/amount per day:_____________Alcohol/amount per day:____________

Do you understand what Biologically Identical Hormone Replacement is? ____________________________

Do you understand the risks involved due to your use of Biologically Identical Hormone Replacement such as myocardial infarction, heart disease, stroke, breast cancer? ________________________________

*It is recommended that you consult with your physician regarding these risks.*

What are your goals for Biologically Identical Hormone Replacement?

**To what degree do you experience the following?**

| | None | Slightly | Moderate | Severe | Extreme |
|---|---|---|---|---|---|
| Difficulty Concentrating | | | | | |
| Can't Sleep (Insomnia) | | | | | |
| Depressed or Unhappy | | | | | |
| Anxious | | | | | |
| Headaches | | | | | |
| Moodiness/Emotional Swings | | | | | |
| Painful or Swollen Breasts | | | | | |
| Weight gain/ Bloating | | | | | |
| PMS | | | | | |
| | **None** | **Slightly** | **Moderate** | **Severe** | **Extreme** |
| Night Sweats | | | | | |

| Difficulty Remembering Things | | | | | |
|---|---|---|---|---|---|
| Brain Fog | | | | | |
| Hot Flashes | | | | | |
| Vaginal Dryness | | | | | |
| Dry Hair/Skin | | | | | |
| Incontinence | | | | | |
| Frequent Urinary Tract Infections | | | | | |
| Inability to Reach Orgasm | | | | | |
| Painful Intercourse | | | | | |
| Lack of Sexual Desire | | | | | |
| Fatigue/Loss of Energy | | | | | |

**General Health:** ☐ Good ☐ Fair ☐ Poor

Height:____________Weight:__________ Do you exercise, describe:______________________________

**Menstrual Cycle:** ☐ None ☐ Regular______________ ☐ Date of last period: ______________

☐ Irregular / Explain (heavy, how long,etc): ________________________

**Surgery:** **Date of Surgery:**

☐ Oophorectomy ________________ (ovaries)
☐ Hysterectomy ________________ (uterus)
☐ Tubal Ligation ________________
☐ Other ________________
☐ None

It is recommended that baseline hormone levels be checked. This can be achieved by testing blood, urine, or saliva. If recommended, we suggest that you test for the following hormones:

Women (For overall health check a,b, and c yearly.)

a. Pap Smear
b. Thyroid: TSH, T3, and T4
c. Cortisol
d. Testosterone (Free & Total)
e. Progesterone
f. Oestradiol, Oestriol and Oestrone
g. DHEA (Sulfate)
h. Vitamin D3 (25 Hydroxy)

Optional: Reverse T3 (practitioner discretion)

If you have recently (2 to 3 months) had a blood, urine, or saliva hormone test, please attach the results to your questionnaire.

Where to go from here:

☐ I would like a recommendation from a pharmacist.
☐ I will take this completed questionnaire to my practitioner.
☐ I will contact my practitioner about further lab testing.

Notes
______________________________________________________________________
______________________________________________________________________

## Section 3. ***MEN ONLY***For Bioidentical Hormone Replacement

**Personal History**

Heart Disease
☐ Diabetes
High Blood Pressure
Smoking History
Impaired Liver Function

Stroke
☐ Adult Mumps
Prostate Operation
Vasectomy
Orchitis (testicular inflammation)

Cancer (type) _______________
☐ Persistent Urinary Tract Infections
Other Testicular Problems
Other _________________
Other _________________

Cholesterol Serum:_______Date:_________ Triglycerides:____ HDL:____ LDL:____ Chol/HDL Ratio:_____

Date of Last Prostate Exam:_________ PSA Results: _________

Current Health Care Provider/s:_______________________________________________________________

**To what degree do you experience the following?**

| | None | Slightly | Moderate | Severe | Extreme |
|---|---|---|---|---|---|
| Fatigue or loss of energy | | | | | |
| Depression, low or negative mood | | | | | |
| Irritability, anger or bad temper | | | | | |
| Anxiety or nervousness | | | | | |
| Lack of motivation | | | | | |
| Loss of memory or concentration | | | | | |
| Impotence / Decreased erections | | | | | |
| Inability to ejaculate | | | | | |
| Dry skin on face or hands | | | | | |
| Weight gain / Increased Abdominal Fat | | | | | |
| Backache, joint pains or stiffness | | | | | |
| Loss of muscle mass/tone | | | | | |
| Decreased Urine Flow | | | | | |
| Increased Urinary Urge | | | | | |
| Sleep Disturbances | | | | | |
| Decreased Libido | | | | | |
| Thinning Hair | | | | | |
| Bone Loss | | | | | |
| Night Sweats | | | | | |
| Brain Fog/ Burned out Feeling | | | | | |
| Decreased Stamina | | | | | |

**General Health:** ☐ Good ☐ Fair ☐ Poor

Height:____________Weight:__________ Do you exercise, describe:_
__________________

**Surgery:** ________________ **Date of Surgery:** ___
________________ ________________
________________ ________________
________________ ________________

Prior Hormone Replacement Therapy History: (include dates of use) _
____________________________________________________________
____________________________________________________________

Are you currently following a special diet (Gluten Free, Casien Free, Arkins, Paleo, etc):_
____________________________________________________________
____________________________________________________________

Do you eat/drink soy:___________Caffeine/amount per day:____________Alcohol/amount per day:_
____________________________

Notes and/or Questions:
____________________________________________________________
____________________________________________________________
____________________________________________________________

It is recommended that baseline hormone levels be checked. This can be achieved by testing blood, urine, or saliva. If recommended, we suggest that you test for the following hormones:
Men

a. PSA
b. Oestradiol (E2)
c. Testosterone (Free & Total)
d. DHT
e. DHEA (Sulfate)
f. Vitamin D3 (25 Hydroxy)
g. Thyroid: TSH, T3, and T4

Optional: Reverse T3 (practitioner discretion)

If you have recently (2 to 3 months) had a blood, urine, or saliva hormone test, please attach the results to your questionnaire.

Where to go from here:

- ☐ I would like a recommendation from a pharmacist.
- ☐ I will take this completed questionnaire to my practitioner.
- ☐ I will contact my practitioner about further lab testing.

Notes and/or Questions:
____________________________________________________________
____________________________________________________________

## SECTION 4. Waiver & Privacy Information

**Waiver** **Last Revised June 2017**

I hereby release My Skin Pharmacy, all its employees and pharmacists from any and all liability whatsoever associated with or connected to my Biologically Identical Hormone Replacement Therapy (BHRT) consultation and/or use of BHRT. I acknowledge that I am legally responsible for and aware of the potential side-effects associated with BHRT. I understand that no doctor, nurse, pharmacist, or administrative personnel can guarantee that BHRT will provide the results I seek. I am participating in this program by my own choice, and assume all responsibility for my use of BHRT.

I fully understand that it is my responsibility to have an annual physical examination along with appropriate laboratory testing. I am currently under the medical supervision of a primary care physician. I have been advised in this hormone self-assessment about the increased risks of heart disease, myocardial infarction, stroke, and breast cancer possibly associated with the use of BHRT. I have answered truthfully all of the questions on this questionnaire.

Signed______________________________________________________Date _______________

## SECTION 5. Where to send your completed Assessment Form

**Send your completed form to:**

Email: info@myskinpharmacy.com.au

Fax: 07 3039 1583