UNIVERSAL ARTS
PHARMACY
Compounding Laboratory

6500 West 4th Avenue, Suite 4
Hialeah, FL 33012
PH 305-556-2673
Fax 305-556-9749
www.uaprx.com

BHRT CONSULTATION AND ASSESSMENT PACKET

1. Please complete the following confidential information packet and mail back to our pharmacist.
2. We respect your confidentiality; please review our privacy (HIPPA) statement enclosed. Please read, sign and submit the attached release forms in order to ensure that you are aware of our privacy practices. Please call us with any questions regarding our privacy statement.
3. Upon receipt of your completed packet, you will be contacted by our Patient Care Coordinator and if desired, a saliva test kit will be mailed to you for analysis of your hormone levels.

❖ **Saliva Testing and Consultation Procedures**

- Our staff will determine the right salivary test for purchase. The test fees are payable at the time of shipment. For more details, please review the attached page on saliva testing.
- Our professional consultation is the best method for optimizing your individualized hormone therapy. It enables our clinical staff to obtain valuable information on your diet, stress, and overall lifestyle. This information will impact your supplement and medication doses. This consultation will enable a more thorough recommendation in BHRT, and as a result, will allow you to regain your hormonal balance and your overall sense of well being.
- Professional consultations are approximately 20 minutes and are typically performed over the telephone. Consultation fees are included in the price of the test.
- Upon review of your saliva test results and your individual consultation, a recommendation will be obtained and forwarded to you and your doctor if requested.

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4. Patient Acknowledgement

I acknowledge the terms and conditions listed above. I am interested in pursuing Bio-Identical Hormone Replacement Therapy with Universal Arts Pharmacy, Compounding Lab, and my health care provider.

Signature ____ **Date** ______________**Credit Card**

5. **Authorization**: **The test fees are payable at the time of shipment for all saliva tests.**

Credit Card Type: o Master Card o Visa o American Express

Credit Card Number: ____ Exp.____________

I authorize payment to Universal Arts Pharmacy, Compounding Laboratory, upon rendering the service as listed above.

Signature___________________________________ **Date** ___________

Print Name ____

BHRT PATIENT INFORMATION AND HEALTH SUMMARY FORM

LAST NAME ____________________________________ **DATE**______________________

FIRST NAME __________________________________ **MIDDLE INITIAL**___________________

ADDRESS_________________________________/_________________/_________/__________
Street City State Zip Code

HOME PHONE ___________________________ **CELL/ALT PHONE** ______________________

WORK PHONE _________________________ **EMAIL ADDRESS** _________________________

DATE OF BIRTH ______/______/______ **SOCIAL SECURITY** ___________________________

SEX: o **Male** o **Female** **HEIGHT**___________ **WEIGHT** ___________

BODY TYPE: o **Apple** o **Pear** o **Other** ________ **BONE SIZE:** o **Small** o **Medium** o **Large**

ALCOHOL: o **Y** o **N** **How much per week?** _____________

DO YOU SMOKE? o **Y** o **N** **If yes, how many packs per day?** __________

DO YOU EXERCISE? o **Y** o **N** **If yes, what type?** ____________ **How often?** _____________

CAFFEINE CONSUMPTION o **Y** o **N** **Type (coffee, soda)** __________ **How much?** ________

DESCRIBE YOUR DIET: ____

____

____

Health Care Provider

- Who referred you to us? ____
- Please list your health care provider information and the date of your last visit:

LAST NAME: _________________________________ FIRST NAME: ___________________________

SPECIALTY: ____

Office Phone Number: _______________________ Office Fax Number: ___________________________

Address: _____________________________________City:___________ State:______ Zip:________

Date of Last Visit: __________________________

Shipping Information

- Please ship medication prescribed to one of the following addresses (please check one):
  - o Patient Address, as listed above
  - o Alternate Shipping Address, specify below:

____

____

____

BHRT PATIENT INFORMATION AND HEALTH SUMMARY FORM

 Medication Allergies:
Please check all that apply.

__ **Penicillin** __ **Morphine** __ **Dye allergies** __ **No known allergies**
__ **Codeine** __ **Aspirin** __ **Nitrate allergy** __ **Seasonal (pollen) allergies**
__ **Sulfa drugs** __ **Pet allergies** __ **Food allergies** **other:** _____________

Please describe the allergic reaction you experience and the frequency at which it occurs.
____
____

 Prescription Medication? o Y o N
If so, list below. Use backside if more room is needed.

Medication Name **Strength** **Date started** **How often per day**
____
____
____
____

 Over-The–Counter Drugs? o Y o N
Please check all products that you use occasionally or regularly.

___ **Aspirin (ex. Bayer®)**
___ **Acetaminophen (ex. Tylenol®)**
___ **Ibuprofen (ex. Advil®, Motrin®)**
___ **Naproxen (ex. Aleve®)**
___ **Ketoprofen (ex Orudis®)**
___ **Cough Suppressant (ex. Robitussin DM®)**
___ **Antihistamine product (ex. Benadryl®)**
___ **Decongestant (ex. Sudafed®)**
___**Combination product (cough+cold))**
___**Sleep Aids (ex. Tylenol PM®)**
___**Anti-diarrhea (ex. Pepto Bismol®)**
___**Laxatives/stool softeners (ex.Correctol®)**
___**Diet Aids/Weight Loss (ex.Dexatrim®)**
___**Antacids (ex. Maalox®)**
___**Acid blockers (ex. Pepcid AC®)**
___**Others:** ______________
____

 Nutritional/Natural Supplements? o Y o N
Please check all products that you use occasionally or regularly and specify the type of nutrient.

___ **Multi-Vitamins**
___ **Single Vitamin Forms** (C, B-complex), ____
___ **Minerals** (calcium, magnesium, zinc, chromium, colloidal minerals) _______________
___ **Herbs** (Echinacea, Ginseng, Ginko Biloba, etc.) ________________________________
___ **Enzymes** (digestive formulas, papaya, bromelain, Co-enzyme Q10, etc.) ____________
___ **Nutrition/protein supplements** (shark cartilage, protein shakes, protein bars, amino acids, fish oils, etc.) ____
___ **Others** (glucosamine, etc.) **Please list:** ____

 List Hormones Previously Taken (Synthetic, Bio-Identical and over-the-counter)**:**

Date started **Date stopped** **Reason**
____
____
____
____

PATIENT NAME ____

BHRT PATIENT INFORMATION AND HEALTH SUMMARY FORM

Current or Past Medical Conditions: (Please check all that apply)

o **High Cholesterol**	o **Headaches/Migraine**
o **Heart Disease**	o **Osteoporosis/Osteopenia**
o **High Blood Pressure**	o **Fractures**
o **Cancer (type:_______________)**	o **Liver Disorder**
o **Ulcers (type:_______________)**	o **Chronic Fatigue Syndrome**
o **Thyroid Disorder**	o **Fibromyalgia**
o **Asthma**	o **Varicose Veins**
o Blood **Clotting Disorder**	o **Kidney Disorder**
o **Diabetes (type:______________)**	o **Gallbladder Disease**
o **Arthritis**	o **Eating Disorder**
o **Depression**	o **Other: ______________________**
o **Epilepsy**	

Family History: (Please check all that apply)

o Cancer (type: ____________)	Family Member(s) __________________________
o Diabetes (type: ____________)	Family Member(s) __________________________
o Osteoporosis	Family Member(s) __________________________
o Heart Disease	Family Member(s) __________________________
o Alzheimer's Disease	Family Member(s) __________________________
o Diabetes	Family Member(s) __________________________

OBSTERICAL HISTORY

- **Are you sexually active? o Y o N**
- **Are you trying to get pregnant? o Y o N**
- **Current method of birth control? ______________________ How long? ____________________**
- **Past birth control and any related problems? ____**
- Have you ever had children? o Y o N Number of : Pregnancies_______ Deliveries________

GYNECOLOGICAL HISTORY

Tests:

- **Mammography Date: ___________ Results: ___________________**
- **Pap Smear Date: ___________ Results: ___________________**

- **Have you ever had an abnormal pap? o Y o N If yes, how was it treated? ________________**
- **Do you perform self-breast exams? o Y o N How often? ______________________________**
- **Do you douche? o Y o N How often? ____**
- **Have you had a hysterectomy? o Y o N If yes, when?_________________________________**
- **Have you had any part or whole ovary removed? o Y o N If yes, when?_________________**
- **Have you ever had a tubal ligation? o Y o N If so, when? ______________________________**

PATIENT NAME ____

BHRT PATIENT INFORMATION AND HEALTH SUMMARY FORM

 Check any of the following problems you may have had:

- o **Sexual problems**
- o **Vaginal infections**
- o **Cervical dysplasia**
- o **Lack of sex drive**
- o **Pelvic infections**
- o **Ovarian cysts**
- o **Painful intercourse**
- o **HSV(vaginal herpes)**
- o **Uterine fibroids**
- o **Vaginal dryness**
- o **HPV(vaginal warts)**
- o **Breast fibroids**
- o **Inability to reach climax**
- o **Cervical cancer**
- o **Lack of energy**
- o **Increased facial and/or body hair growth**

MENSTRUAL HISTORY

 As a teenager, were your periods…

- o **regular**
- o **irregular**
- o **light**
- o **heavy**
- o **spotty**
- o **clots**

 P.M.S. …

- o **sometimes**
- o **each time**
- o **severe**
- o **didn't notice**

 Presently…

- o **regular**
- o **irregular**
- o **light**
- o **heavy**
- o **sporadic**
- o **no periods**

 Do you have, or did you ever have Pre Menstrual Syndrome (PMS)? o Y o N

If so, explain symptoms: ____

 When was your last menstrual period? _____________ How long did it last? __________ days

 Do you have any bleeding/spotting between periods? o Y o N When? ___________________

 Other Medical Test and Results:

	Approximate Date	**Results**
Bone density	________________	____________________________
Cholesterol	________________	____________________________
Hormone panel	________________	____________________________
Thyroid panel	________________	____________________________

 How did you arrive at the decision to consider Bio-Identical Hormone Replacement Therapy?

o **Doctor** o **Self** o **Friend/Family** o **Other____________________**

 Please write down any pertinent questions/concerns you may have about BHRT.

PATIENT NAME ____

BHRT Patient Information and Health Summary Form

Please check all symptoms and the degree of the symptom's intensity you have experienced over the past month.

Symptoms	Mild	Moderate	Severe
1. Fibrocystic Breast			
2. Weight Gain			
3. Heavy/Irregular Menses			
4. Hot Flashes			
5. Dry Skin/Hair			
6. Anxiety			
7. Depression			
8. Night Sweats			
9. Vaginal Dryness			
10. Headaches			
11. Irritability			
12. Mood Swings			
13. Breast Tenderness			
14. Sleep Disturbances/ Insomnia			
15. Cramps			
16. Fluid Retention			
17. Breakthrough Bleeding			
18. Fatigue			
19. Loss of Memory			
20. Bladder Symptoms			
21. Arthritis			
22. Harder to Reach Climax			
23. Decreased Sex Drive			
24. Hair Loss			

PATIENT NAME ____

BHRT PATIENT INFORMATION AND HEALTH SUMMARY FORM

NAME ___________________________/________________________________/____________
Last First M.I.

ADDRESS________________________________/______________/_______/_____________
Street City State Zip Code

PHONE (______) ______-_______ **SEX** o **Male** o **Female** **DOB** ______/______/______

RECOMMENDATION: ASSESSMENT AND PLAN

PRACTICIONER SIGNATURE: ________________________________ **DATE:** _______

Comments:
____
____
____

Note:

The recommendations you have obtained are Universal Arts Pharmacy, Compounding Laboratory's interpretation of your salivary test and/or other pertinent information. These recommendations are not intended to be indicative of a final diagnosis. Pharmacotherapy suggestions based upon this evaluation must be interpreted by a licensed health care provider in order to validate and implement therapy by prescription order only. Please forward and discuss this information with your medical provider.

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Authorization for the Release of Medical Records

I, ____
(Print your name)

Request that Dr. _________________________________release

__________ All records

__________ Laboratory studies, dated _____________

To: Universal Arts Pharmacy, Compounding Lab
6500 West 4th Ave, Suite 4
Hialeah, FL 33146

Patient Signature ______________________________________

Date of Birth: ____________________

Social Security: ___________________

Witness: ____

Date: ____________

Compounding Pharmacy

6500 West 4th Ave., Suite 4
Hialeah, Florida 33012
www.uaprx.com

Dear Patient:

Health Care Providers have always protected the confidentiality of health information and have refused to reveal such information. Today, state and federal laws are also attempting to ensure the confidentiality of this sensitive information.

The regulation, effective April 14th 2003, protects virtually all patients, regardless of where they live or where they receive their health care. Every time you see a physician, are admitted to a hospital, fill a prescription, or send a claim to health plan, these professionals will need to consider the privacy rule. All health information, including paper records, oral communication, and electronic formats (such as email and electronic claim filing) are protected by the privacy rule.

Our privacy notice form, *How We Are Going to Use and Protect Your Health Information*, is available at our pharmacy and has been enclosed in your packet. It contains information about how your confidentiality is protected by our Pharmacy. The privacy rule provides you certain rights, such as the right to have access to your medical records: However, because there are no exceptions to these rights, they are not absolute. Please read our privacy notice titled, *How We Are Going to Use and Protect Your Health Information*, as your signed consent is required.

Please let us know if you have any questions about our privacy statement. To contact our pharmacy, please call 305-556-2673.

Privacy Acknowledgement

I have read, and I understand Universal Arts Pharmacy, Compounding Laboratory's privacy notice, *How We Are Going TO Use and Protect Your Health Information*.

Date __________ Signature ____________________________________

Print Name ____________________________________