

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.

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: Master Card Visa 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: Male Female HEIGHT _____ WEIGHT _____

BODY TYPE: Apple Pear Other _____ BONE SIZE: Small Medium Large

ALCOHOL: Y N How much per week? _____

DO YOU SMOKE? Y N If yes, how many packs per day? _____

DO YOU EXERCISE? Y N If yes, what type? _____ How often? _____

CAFFEINE CONSUMPTION Y 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):

- Patient Address, as listed above
- 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? Y N

If so, list below. Use backside if more room is needed.

Medication Name	Strength	Date started	How often per day
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Over-The-Counter Drugs? Y N

Please check all products that you use occasionally or regularly.

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

Nutritional/Natural Supplements? Y 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
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PATIENT NAME _____

BHRT PATIENT INFORMATION AND HEALTH SUMMARY FORM

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

<ul style="list-style-type: none"> <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Cancer (type: _____) <input type="checkbox"/> Ulcers (type: _____) <input type="checkbox"/> Thyroid Disorder <input type="checkbox"/> Asthma <input type="checkbox"/> Blood Clotting Disorder <input type="checkbox"/> Diabetes (type: _____) <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Epilepsy 	<ul style="list-style-type: none"> <input type="checkbox"/> Headaches/Migraine <input type="checkbox"/> Osteoporosis/Osteopenia <input type="checkbox"/> Fractures <input type="checkbox"/> Liver Disorder <input type="checkbox"/> Chronic Fatigue Syndrome <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Kidney Disorder <input type="checkbox"/> Gallbladder Disease <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Other: _____
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Family History: (Please check all that apply)

<ul style="list-style-type: none"> <input type="checkbox"/> Cancer (type: _____) <input type="checkbox"/> Diabetes (type: _____) <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Heart Disease <input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Diabetes 	<ul style="list-style-type: none"> Family Member(s) _____ Family Member(s) _____ Family Member(s) _____ Family Member(s) _____ Family Member(s) _____ Family Member(s) _____
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OBSTETRICAL HISTORY

- Are you sexually active? Y N
- Are you trying to get pregnant? Y N
- Current method of birth control? _____ How long? _____
- Past birth control and any related problems? _____
- Have you ever had children? Y N Number of : Pregnancies _____ Deliveries _____

GYNECOLOGICAL HISTORY

Tests:

- Mammography Date: _____ Results: _____
- Pap Smear Date: _____ Results: _____
- Have you ever had an abnormal pap? Y N If yes, how was it treated? _____
- Do you perform self-breast exams? Y N How often? _____
- Do you douche? Y N How often? _____
- Have you had a hysterectomy? Y N If yes, when? _____
- Have you had any part or whole ovary removed? Y N If yes, when? _____
- Have you ever had a tubal ligation? Y N If so, when? _____

PATIENT NAME _____

BHRT PATIENT INFORMATION AND HEALTH SUMMARY FORM

Check any of the following problems you may have had:

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

MENSTRUAL HISTORY

As a teenager, were your periods...

- regular
- light
- spotty
- irregular
- heavy
- clots

P.M.S. ...

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

Presently...

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

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

- Doctor
- Self
- Friend/Family
- 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 _____



Compounding Laboratory

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

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: _____



6500 West 4th Ave., Suite 4
Hialeah, Florida 33012
www.uapr.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 _____