

# Medical History Form

**\$100 Non-Refundable  
Deposit Due at Appointment  
Scheduling!**

Please return your form to the Pharmacy when you have finished.  
The Pharmacist will meet with you to review your information. Thank you.

## 1. Patient Information:

Today's Date: \_\_\_\_\_  
Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_  
Zip: \_\_\_\_\_  
Home/Work Phone#: \_\_\_\_\_ Email address: \_\_\_\_\_  
Payment type: \_\_\_\_\_ Credit Card (MC/Visa/Discover) \_\_\_\_\_ Cash \_\_\_\_\_ Other  
Credit Card # \_\_\_\_\_ Expiration \_\_\_\_\_  
Gender: Male Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_

## 2. Lifestyle Information:

	Do you use? Yes or No	If Yes, how often and how much?
Tobacco (smoke, chew, dip)		
Alcohol (beer, wine, hard liquor)		
Caffeine (cola drinks, tea, coffee)		

**IMPAIRMENTS:** Check if you have any of the following:

Physical impairment       Visual Impairment       Hearing Impairment

**EXERCISE:** Do you exercise regularly?       YES       NO

If YES, describe what you do and how often:

**STRESS MANAGEMENT:** Do you practice any stress management techniques?       YES       NO

If YES, describe what you do and how often:

**DIET:** Describe your typical daily food intake:

First Meal:

Second Meal:

Third Meal:

Any snacks/other:

**1. Doctor Information:** Are you currently under the care of a physician?       YES       NO

If YES, please list each doctor from whom you seek care, including address and phone number, if known:

Doctor name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Doctor name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Doctor name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Name: \_\_\_\_\_ SS#: \_\_\_\_\_

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**4. Allergies: Please check all that apply:**

- penicillin                       morphine                       dye allergies                       pet allergies  
 codeine                       aspirin                       nitrate allergy                       seasonal (pollen) allergies  
 sulfa drug                       food allergies                       no known allergies                      other: \_\_\_\_\_

Please describe the allergic reaction you experienced and when it occurred:

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**5. Over-the-counter (OTC) issues:**

**Please check all products that you use occasionally or regularly. Check all that apply.**

- Pain reliever                       Combination product (cough+cold reliever)(example: Triaminic DM®)  
 Aspirin                       Sleep Aids (examples: Excedrin PM®, Unisom®, Sominex®, Nytol®)  
 Acetaminophen (example: Tylenol®)                       Antidiarrheals (examples: Imodium®, Pepto Bismol®, Kaopectate®)  
 Ibuprofen (example: Motrin IB®)                       Laxatives/stool softeners (examples: Doxidan®, Correctol®, etc.)  
 Naproxen (example: Aleve®)                       Diet aids/weight loss products (examples: Doxatrim®)  
 Ketoprofen (example: Orudis KT®)                       Antacids (examples: Maalox®, Mylanta®)  
 Cough Suppressant (example: Robitussin DM®)                       Acid Blockers (examples: Tagamet HB®, Pepcid AC®, Zantac 75®)  
 Antihistamine (example: Chlor-Trimeton®)                       Others (please list:)  
 Decongestant product (example: Sudafed®) \_\_\_\_\_

**Nutritional/Natural Supplements: Please identify and list the products you are using:**

- vitamins (examples: multiple or single vitamins such as B complex, E, C, beta carotene)  
\_\_\_\_\_  
 minerals (examples: calcium, magnesium, chromium, colloidal minerals, various single minerals)  
\_\_\_\_\_  
 herbs (examples: Ginseng, Ginkgo Biloba, Echinacea, other herbal medicinal teas, tinctures, remedies, etc.)  
\_\_\_\_\_  
 enzymes (examples: digestive formulas, papaya, bromelain, CoEnzyme Q10, etc.)  
\_\_\_\_\_  
 nutrition/protein supplements (examples: shark cartilage, protein powders, amino acids, fish oils, etc.)  
\_\_\_\_\_  
 others (glucosamine, etc.)  
\_\_\_\_\_
- 

**6. Medical Conditions/Diseases: Please check all that apply to you.**

- Heart Disease (example: Congestive Heart Failure)                       Lung condition (examples: asthma, emphysema, COPD)  
 High cholesterol or lipids (example: Hyperlipidemia)                       Diabetes  
 High blood pressure (example: Hypertension)                       Arthritis or joint problems  
 Cancer                       Depression  
 Ulcers (stomach, esophagus)                       Epilepsy  
 Thyroid disease                       Headaches/migraines  
 Hormonal Related Issues                       Eye Disease (glaucoma, etc.)  
 Blood Clotting Problems                       Others (please list:)
- 

**7. Prescription Medications:**

Please list all prescription medications you are currently using. Be sure to include any mail order or physician samples.

<u>Medication Name</u>	<u>Dose</u>	<u>How many times per day?</u>	<u>Doctor</u>
1. _____			
2. _____			
3. _____			
4. _____			
5. _____			
6. _____			

Patient Name: \_\_\_\_\_ SS#: \_\_\_\_\_

## Menstrual Cycle:

1. Since you first began having periods, have you ever had what you would consider to be abnormal cycles?

Yes       No      Date of Cycle: \_\_\_\_\_

If yes, please explain (such as age, when this occurred, symptoms, etc.)

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2. When was your last period? \_\_\_\_\_ How many days did it last? \_\_\_\_\_

3. How many days from the start of one period to another? \_\_\_\_\_

4. How many days of bleeding? \_\_\_\_\_

5. Do you have, or did you ever have Premenstrual Syndrome (PMS)?     Yes       No

If yes, please explain symptoms: \_\_\_\_\_

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When do they start? \_\_\_\_\_ When do they end? \_\_\_\_\_

6. Do you experience cramping?     Yes       No

If yes, please describe: \_\_\_\_\_

7. Have you experienced recent changes in your normal cycle?     Yes       No

If yes, please describe: \_\_\_\_\_

8. Do you experience any bleeding between periods?     Yes       No

9. Do you experience any:

Pelvic pain?     Yes       No      If yes, please describe: \_\_\_\_\_

Pelvic pressure?     Yes       No      If yes, please describe: \_\_\_\_\_

Fullness?     Yes       No      If yes, please describe: \_\_\_\_\_

10. Do you experience any unusual vaginal itching?     Yes       No

Patient Name: \_\_\_\_\_ SS#: \_\_\_\_\_

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# MEDICAL HISTORY FORM — PATIENT SPECIFIC INFORMATION

## TESTS:

1. Have you had any of the following tests performed? Check those that apply and note date of last test.

Mammography	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Test: _____
PAP Smear	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Test: _____
Pelvic Exam	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Test: _____

2. Have you ever had an abnormal PAP?  Yes  No

If yes, what treatment was done? \_\_\_\_\_

3. When did you last have your cholesterol checked? \_\_\_\_\_ Results: \_\_\_\_\_

4. Do you have any lab volumes you can provide from your last physical with your doctor?  Yes  No

If yes, what lab volumes can you provide: \_\_\_\_\_

5. Have you ever had a bone density scan?  Yes  No

If yes, when? \_\_\_\_\_ Results: \_\_\_\_\_

**FAMILY HISTORY:**

1. Please list family members - and their age - who have had serious diseases such as diabetes, heart disease, cancer, osteoporosis, etc.

Disease: \_\_\_\_\_ Relation: \_\_\_\_\_ Age: \_\_\_\_\_  
Disease: \_\_\_\_\_ Relation: \_\_\_\_\_ Age: \_\_\_\_\_  
Disease: \_\_\_\_\_ Relation: \_\_\_\_\_ Age: \_\_\_\_\_  
Disease: \_\_\_\_\_ Relation: \_\_\_\_\_ Age: \_\_\_\_\_

1. Please list any family members who have died from serious diseases.

Disease: \_\_\_\_\_ Relation: \_\_\_\_\_ Age: \_\_\_\_\_  
Disease: \_\_\_\_\_ Relation: \_\_\_\_\_ Age: \_\_\_\_\_  
Disease: \_\_\_\_\_ Relation: \_\_\_\_\_ Age: \_\_\_\_\_  
Disease: \_\_\_\_\_ Relation: \_\_\_\_\_ Age: \_\_\_\_\_

3. Do you have a family history of any of the following?

Uterine Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Family Member (s) _____
Ovarian Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Family Member (s) _____
Fibrocystic Breast	<input type="checkbox"/> Yes <input type="checkbox"/> No	Family Member (s) _____
Breast Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Family Member (s) _____
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Family Member (s) _____
Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Family Member (s) _____
Prematurely gray	<input type="checkbox"/> Yes <input type="checkbox"/> No	Family Member (s) _____

Patient Name: \_\_\_\_\_ SS#: \_\_\_\_\_

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**MEDICATIONS PREVIOUSLY TAKEN:**

1. Have you been on hormones (natural or synthetic) previously?  Yes  No

If yes, please answer the following:

Hormone: \_\_\_\_\_ Date Started: \_\_\_\_\_ Date Stopped? \_\_\_\_\_ Why? \_\_\_\_\_

Hormone: \_\_\_\_\_ Date Started: \_\_\_\_\_ Date Stopped? \_\_\_\_\_ Why? \_\_\_\_\_

Hormone: \_\_\_\_\_ Date Started: \_\_\_\_\_ Date Stopped? \_\_\_\_\_ Why? \_\_\_\_\_

Hormone: \_\_\_\_\_ Date Started: \_\_\_\_\_ Date Stopped? \_\_\_\_\_ Why? \_\_\_\_\_

Hormone: \_\_\_\_\_ Date Started: \_\_\_\_\_ Date Stopped? \_\_\_\_\_ Why? \_\_\_\_\_

**BODY TYPE:**

1. What is your bone size?  Small  Medium  Large

2. What is your body type?  Androgenic  Estrogenic

**CONTRACEPTIVES:**

1. Have you ever used oral contraceptives?  Yes  No

2. If you answered yes, to using oral contraceptives, please answer the following questions.

Oral Contraceptive Used? \_\_\_\_\_ Date Started: \_\_\_\_\_ Date Stopped? \_\_\_\_\_

Oral Contraceptive Used? \_\_\_\_\_ Date Started: \_\_\_\_\_ Date Stopped? \_\_\_\_\_

Oral Contraceptive Used? \_\_\_\_\_ Date Started: \_\_\_\_\_ Date Stopped? \_\_\_\_\_

Oral Contraceptive Used? \_\_\_\_\_ Date Started: \_\_\_\_\_ Date Stopped? \_\_\_\_\_

3. Did you have any problems using oral contraceptives?  Yes  No

If yes, please describe any problem: \_\_\_\_\_

\_\_\_\_\_

**NATURAL HORMONE REPLACEMENT:**

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

Doctor  Self  Friend or Family Member  Other, please describe: \_\_\_\_\_

2. What are your goals with taking Bio-Identical Hormone Replacement Therapy?.

\_\_\_\_\_

\_\_\_\_\_

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**PREGNANCY:**

- 1. How many pregnancies have you had? \_\_\_\_\_
- 2. How many children? \_\_\_\_\_
- 3. Any complications? \_\_\_\_\_
- 4. Any interrupted pregnancies?      \_\_\_ Yes    \_\_\_ No      If yes, how many? \_\_\_\_\_
- 5. Have you had an hysterectomy?      \_\_\_ Yes    \_\_\_ No      Date of Surgery? \_\_\_\_\_
- 6. Have you had your ovaries removed?    \_\_\_ Yes    \_\_\_ No      Date of Surgery? \_\_\_\_\_
- 7. Are your ovaries intact?                \_\_\_ Yes    \_\_\_ No      Date of Surgery? \_\_\_\_\_
- 8. Have you had tubal ligation?            \_\_\_ Yes    \_\_\_ No      Date of Surgery? \_\_\_\_\_
- 9. Have you used birth control pills?      \_\_\_ Yes    \_\_\_ No      How long? \_\_\_\_\_

**SYMPTOMS:**

1. If you have experienced any of the following symptoms please place a number in the appropriate area.

- 0 = Rarely a Problem
- 1 = Mild
- 2 = Moderate
- 3 = This is serious for me

- |                              |                              |                           |                  |
|------------------------------|------------------------------|---------------------------|------------------|
| ___ Headache                 | ___ Difficulty Concentrating | ___ Night Sweats          | ___ Cramps       |
| ___ Heart Palpitations       | ___ Fibrocystic Breasts      | ___ Feeling of Depression | ___ Anxiety      |
| ___ Weight Gain              | ___ Vaginal Dryness          | ___ Yeast Infections      | ___ Moodiness    |
| ___ Uterine Fibroids         | ___ Swollen Breasts          | ___ Food Cravings         | ___ Bloating     |
| ___ Dry Hair or Skin         | ___ Loss of Pubic Hair       | ___ Low Body Temperature  | ___ Irritability |
| ___ Hot Flashes              | ___ Hair Loss                | ___ Painful Intercourse   | ___ Mood Swings  |
| ___ Increased Facial Hair    | ___ Difficulty Sleeping      | ___ Shortness of Breath   | ___ Fatigue      |
| ___ Urinary Tract Infections | ___ Foggy Thinking           |                           |                  |

2. Circle any of the following you experienced.

- |                 |                     |          |                    |                   |
|-----------------|---------------------|----------|--------------------|-------------------|
| Heart Trouble   | High Blood Pressure | Stroke   | Varicose Veins     | Clotting Problems |
| Diabetes        | Kidney Trouble      | Epilepsy | Fractures          | Arthritis         |
| Colitis         | Gallbladder Trouble | Asthma   | Chronic Fatigue    | Fibromyalgia      |
| Eating Disorder | Digestion Problems  | Cancer   | Multiple Sclerosis |                   |

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# Doctor Medical Release Authorization

“I hereby authorize my Physician to furnish an agent of Martin Avenue Pharmacy, Inc. any and all records pertaining to my medical history, services rendered and / of treatments. I understand that employees of Martin Avenue Pharmacy, Inc. will protect my privacy and this information will be released to other health care professionals only whend it is necessary in order to provide health care services to me. I further understand that a Martin Avenue Pharmacy, Inc. employee will not release this information unless authorized by me in writing. This authority shall continue until revoked by me in writing.”

Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

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Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Pharmacy Record Release Authorization

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

Name	Address	Telephone
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____

I understand that employees of Martin Avenue Pharmacy, Inc. will protect my privacy and this information will be released to other health care professionals only when it is necessary in order to provide health care services to me. This authority shall continue until revoked by me in writing.

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Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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# Question Documentation Form

Please write down any questions you may have about Prescription Natural Hormone Replacement Therapy (Rx NHRT), 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 / nurse. Thank you.

1.

2.

3.

4.

5.

6.

7.

8.

Patient Name: \_\_\_\_\_ SS#: \_\_\_\_\_

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# STATEMENT OF MEDICAL NEED

Patient Name:		DOB:	
Address:		Phone: (    )	
City:	State:	Zip:	
ICD-9:	ICD-9:	ICD-9:	ICD-9:
<b>Service/Intervention</b> <input type="checkbox"/> Additional Medication Counseling <input type="checkbox"/> Injection Training Specify Device: _____		<input type="checkbox"/> Medication Review & Evaluation <input type="checkbox"/> Device Training Specify Device: _____ <input type="checkbox"/> Body Fat Analysis (electrolipograph) <input type="checkbox"/> Weight Monitoring	
<b>Asthma/COPD Coordination of Care</b> <input type="checkbox"/> General Asthma/COPD Education <input type="checkbox"/> Childhood Asthma Education <input type="checkbox"/> Pregnancy & Asthma Education <input type="checkbox"/> Environmental Control <input type="checkbox"/> Allergen Avoidance <input type="checkbox"/> Smoking & Asthma/COPD <input type="checkbox"/> MDI/Spacer Education <input type="checkbox"/> Peak Flow Monitoring <input type="checkbox"/> Asthma/COPD Care Diary		<b>Diabetes Coordination of Care</b> <input type="checkbox"/> Diabetes Mellitus Education (circle: type 1 type 2) <input type="checkbox"/> Lifestyle Modifications (diet, exercise, stress mgmt) <input type="checkbox"/> Complications of Diabetes <input type="checkbox"/> Hypo/Hyperglycemia Management <input type="checkbox"/> Eye & Foot Care <input type="checkbox"/> Injection Device Training <input type="checkbox"/> Blood Glucose Monitor Training <input type="checkbox"/> Home Blood Glucose Monitoring Education <input type="checkbox"/> Glucose Monitoring Diary	
<b>Hyperlipidemia Coordination of Care</b> <input type="checkbox"/> Dyslipidemia Education <input type="checkbox"/> Complications of Dyslipidemia <input type="checkbox"/> Risk Factors Education <input type="checkbox"/> Lifestyle Modifications (diet, exercise, stress mgmt) <input type="checkbox"/> Total Cholesterol Monitoring <input type="checkbox"/> Lipid Profile Monitoring (fasting) <input type="checkbox"/> Framingham Risk Assessment <input type="checkbox"/> Body Fat Analysis (electrolipograph) <input type="checkbox"/> Weight Monitoring <input type="checkbox"/> Blood Pressure Monitoring		<b>Cardiovascular Coordination of Care</b> <input type="checkbox"/> Cardiac Disease Education <input type="checkbox"/> Hypertension Education <input type="checkbox"/> Lifestyle Modifications (diet, exercise) <input type="checkbox"/> Sodium Restriction <input type="checkbox"/> Alcohol & Tobacco Elimination <input type="checkbox"/> Relaxation & Stress Reduction Techniques <input type="checkbox"/> Body Fat Analysis (electrolipograph) <input type="checkbox"/> Weight Monitoring <input type="checkbox"/> Blood Pressure Monitoring <input type="checkbox"/> Anticoagulation Monitoring (PT/INR)	
<b>Anticoagulation Coordination of Care</b> <input type="checkbox"/> Anticoagulation Monitoring (PT/INR) <input type="checkbox"/> Coagulation Meter Use Training <input type="checkbox"/> Detailed Anticoagulation Education <input type="checkbox"/> Atrial Fibrillation Education <input type="checkbox"/> DVT/PE Education <input type="checkbox"/> Dietary Concerns <input type="checkbox"/> OTC and Natural Product Education <input type="checkbox"/> Lifestyle Modifications (ADL, exercise)		<b>Natural H.R.T. Coordination of Care</b> <input type="checkbox"/> Lifestyle Modifications <input type="checkbox"/> Medication Dosage Calculations <input type="checkbox"/> Dosage Form Review <input type="checkbox"/> Dietary Concerns (calcium, Vitamin D, etc.) <input type="checkbox"/> OTC and Natural Product Education <input type="checkbox"/> Risk Factors Education <input type="checkbox"/> Lipid Profile Monitoring (TC, HDL, LDL, TG) Other: _____	

I have asked \_\_\_\_\_ Pharmacy to evaluate this patient and recommend solutions to the patient's problem(s).

Also, I request that a \_\_\_\_\_ pharmacist and/or nurse implement programs to correct the problem(s) under his/her control.

**Goals and Duration of Intervention:**

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(Continue on back if necessary)

“I consider this program to be a necessary part of this patient's medical care.”

\_\_\_\_\_  
Physician's Signature  
Printed Name \_\_\_\_\_

\_\_\_\_\_  
Date  
UPIN# \_\_\_\_\_

Patient Name: _____	SS#: _____
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