Medical History Form

$200 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#: _____

72 Hour Notice
Required for Cancellation!

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:

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

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

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

_____

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

Medication Name	Dose	How many times per day?	Doctor
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.)

   _____

   _____

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: _____

   _____

   _____

   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#: _____

72 Hour Notice Required for Cancellation!

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	___ Yes	___ No	Date of Test: _____
PAP Smear	___ Yes	___ No	Date of Test: _____
Pelvic Exam	___ Yes	___ 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 afamily history of any of the following?

Uterine Cancer ___ Yes ___ No Family Member (s) _____

Ovarian Cancer ___ Yes ___ No Family Member (s) _____

Fibrocystic Breast ___ Yes ___ No Family Member (s) _____

Breast Cancer ___ Yes ___ No Family Member (s) _____

Heart Disease ___ Yes ___ No Family Member (s) _____

Osteoporosis ___ Yes ___ No Family Member (s) _____

Prematurely gray ___ Yes ___ No Family Member (s) _____

Patient Name: _____ SS#: _____

Martin Avenue Pharmacy, Inc. • 1247 Rickert Drive • Naperville, IL 60540 • Phone: 630-355-6400

72 Hour Notice Required for Cancellation!

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?.

   _____

   _____

Patient Name: _____ SS#: _____

72 Hour Notice Required for Cancellation!

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	

Patient Name: _____ SS#: _____

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: _____

Patient Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Signature: _____ **Date:** _____

Pharmacy Record Release Authorization

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.

Patient Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Signature: _____ **Date:** _____

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#: _____

Martin Avenue Pharmacy, Inc. • 1247 Rickert Drive • Naperville, IL 60540 • Phone: 630-355-6400

72 Hour Notice Required for Cancellation!

STATEMENT OF MEDICAL NEED

Patient Name:			DOB:
Address:			Phone: ( )
City:	State:		Zip:
ICD-9:	ICD-9:	ICD-9:	ICD-9:

Service/Intervention

___ Additional Medication Counseling
___ Injection Training
Specify Device: _____

___ Medication Review & Evaluation
___ Device Training
Specify Device: _____
___ Body Fat Analysis (electrolipograph)
___ Weight Monitoring

___ Compliance Assessment
___ Side Effect Analysis
___ FDA MedWatch® Report
___ Stress/ADE Management
___ Other:

Asthma/COPD Coordination of Care

___ General Asthma/COPD Education
___ Childhood Asthma Education
___ Pregnancy & Asthma Education
___ Environmental Control
___ Allergen Avoidance
___ Smoking & Asthma/COPD
___ MDI/Spacer Education
___ Peak Flow Monitoring
___ Asthma/COPD Care Diary

Diabetes Coordination of Care

___ Diabetes Mellitus Education (circle: type 1 type 2)
___ Lifestyle Modifications (diet, exercise, stress mgmt)
___ Complications of Diabetes
___ Hypo/Hyperglycemia Management
___ Eye & Foot Care
___ Injection Device Training
___ Blood Glucose Monitor Training
___ Home Blood Glucose Monitoring Education
___ Glucose Monitoring Diary

Hyperlipidemia Coordination of Care

___ Dyslipidemia Education
___ Complications of Dyslipidemia
___ Risk Factors Education
___ Lifestyle Modifications (diet, exercise, stress mgmt)
___ Total Cholesterol Monitoring
___ Lipid Profile Monitoring (fasting)
___ Framingham Risk Assessment
___ Body Fat Analysis (electrolipograph)
___ Weight Monitoring
___ Blood Pressure Monitoring

Cardiovascular Coordination of Care

___ Cardiac Disease Education
___ Hypertension Education
___ Lifestyle Modifications (diet, exercise)
___ Sodium Restriction
___ Alcohol & Tobacco Elimination
___ Relaxation & Stress Reduction Techniques
___ Body Fat Analysis (electrolipograph)
___ Weight Monitoring
___ Blood Pressure Monitoring
___ Anticoagulation Monitoring (PT/INR)

Anticoagulation Coordination of Care

___ Anticoagulation Monitoring (PT/INR)
___ Coagulation Meter Use Training
___ Detailed Anticoagulation Education
___ Atrial Fibrillation Education
___ DVT/PE Education
___ Dietary Concerns
___ OTC and Natural Product Education
___ Lifestyle Modifications (ADL, exercise)

Natural H.R.T. Coordination of Care

___ Lifestyle Modifications
___ Medication Dosage Calculations
___ Dosage Form Review
___ Dietary Concerns (calcium, Vitamin D, etc.)
___ OTC and Natural Product Education
___ Risk Factors Education
___ 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:

_____

_____

(Continue on back if necessary)

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

_____ _____

Physician's Signature Date

Printed Name _____ UPIN# _____

Patient Name: _____ SS#: _____