jayhawk pharmacy
& patient supply

Bio-Identical Hormone Replacement Therapy (BHRT) Assessment and Consultation Checklist

These items must be completed and on file with the pharmacy prior to your evaluation:

-Pharmacy Record Release Authorization Form

-Confidential Personal Medical History Form

-Hormone Replacement Therapy Patient Information Sheet

-Question Documentation Form (any questions you might have for our pharmacist)

-Provide copies of any relevant blood and/or saliva tests results if available (i.e. estradiol, estriol, estrone, progesterone, testosterone, cortisol, etc.)

-Return all materials to the pharmacy (by mail or in-person) prior to scheduling your 1-hour consultation with our pharmacist, **Scott Engle, PharmD, Certified HRT Specialist**

Jayhawk Custom Pharmacy
6730 SW. 29th St. Ste. C
Topeka, KS 66614
Phone: (785) 228-9740   Fax: (785) 228-9745

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:

Physician Name	Office Address	Telephone
1)		
2)		
3)		

Patient Name: ______________________________

Address: ______________________________

City, State, Zip ______________________________

Phone: ______________________________

Signature: ______________________________

Date: ______________________________

BIO-IDENTICAL HORMONE REPLACEMENT THERAPY QUESTIONAIRE

NAME OF PATIENT: ____ **DATE OF BIRTH:** ____/_____/___

ADDRESS: ___________________________ **CITY:** _______________ **STATE:** _______________ **ZIP:** ____________

HOME PHONE: (____) ______________ **WORK:** (____) ____________________ **CELL:** (____) ______________________

E-MAIL: ___________________________________ **SOCIAL SECURITY/DRIVERS LICENSE NUMBER:** ____________________

HEIGHT: ___________________ **WEIGHT:** _____________________ **How far from personal goal weight?** _________________

MEDICAL CONTACT

PRIMARY PHYSICIAN: _______________________________ **PHYSICIAN PHONE:** (____) ___________________

DATE OF LAST PHYSICAL EXAMINATION: ___________ **RESULTS:** ____

Have you discussed your hormone replacement therapy goals with your primary care provider? If YES, please explain:

____

What were their comments and recommendations? ____

Do you have any concerns with hormone replacement therapy? ____

PERSONAL OVERVIEW

Are your still menstruating? **YES** **NO**

Date of last menstrual period: ____________

How regular are your menstrual periods? ____

Do you still have your ovaries? **YES** **NO**

Do you still have your uterus? **YES** **NO** **DATE OF SURGERY:** ____________ **REASON:** __________________________

How many pregnancies have you experienced? ______________________

How many children have you had? _________________________________

At what age did your mother reach menopause? ______________________

At what age did your sisters reach menopause? ______________________

Discuss any allergies you have:

Foods: ____

Medications: ____

Other: ____

Are you lactose intolerant? **YES** **NO**

PREVIOUS EXPERIENCE WITH BIO-IDENTICAL HORMONE REPLACEMENT THERAPY (BHRT)

Discuss any previous Hormone Replacement Therapy:

Start date: ____________________ **What did you try?** ____

What did you like? ____

What did you dislike? ____

Reasons for discontinuing: ____

Discuss any current Hormone Replacement Therapy:

Start date of the therapy: ___________________ **What are you using?** ____

What do you like? ____

What do you dislike? ____

PERSONAL MEDICAL HISTORY

Please indicate any previous or current medical conditions and the date of diagnosis:

YES	NO	MEDICAL CONDITION	DATE OF DIAGNOSIS
		Angina/ Chest Pain	
		Anxiety	
		Blood Clot	
		Bone Fracture	
		Cancer	
		Depression	
		Endometriosis	
		Fibrocystic Breast Disease	
		Heart Attack	
		Heart Disease	
		High Blood Pressure	
		Lupus	
		Migraine	
		Obesity	
		Rheumatoid Arthritis	
		Osteoporosis	
		Prematurely Gray	
		Sleep Apnea	
		Other	

FAMILY MEDICAL HISTORY

Please indicate any previous or current medical condition and the relationship to the person:

YES	NO	MEDICAL CONDITION	RELATIONSHIP
		Angina/ Chest Pain	
		Anxiety	
		Blood Clot	
		Bone Fracture	
		Cancer	
		Depression	
		Endometriosis	
		Fibrocystic Breast Disease	
		Heart Attack	
		Heart Disease	
		High Blood Pressure	
		Lupus	
		Migraine	
		Obesity	
		Rheumatoid Arthritis	
		Osteoporosis	
		Prematurely Gray	
		Sleep Apnea	
		Other	

MENSTRUAL OVERVIEW

ADOLESCENCE

Age at which menstrual period began: ___________________________

How would you describe your menstrual cycle during adolescence?

	Light
	Moderate
	Heavy
	Unbearable

How would you describe your physical and/or emotional state one week before your menstrual cycle at that time?

____

ADULTHOOD

How would you describe your menstrual cycle during adulthood?

	Light
	Moderate
	Heavy
	Unbearable

How would you describe your physical and/or emotional state one week before your menstrual cycle at that time?

____

If you currently have your menstrual cycle, is it the same as listed above? YES NO

Are you currently sexually active? YES NO

Are you satisfied with your current sexual activity? YES NO

What would you like to change about your sexual activity? ____

Have you previously taken oral contraceptives? YES NO

Name: ____

How long: ____

**Issues with use: ____

CURRENT PRESCRIPTION MEDICATIONS

Medication	Reason	Duration of Treatment	Prescribing Physician

CURRENT NON-PRESCRIPTION MEDICATIONS

Medication	Reason	Duration of Treatment

CURRENT VITAMIN/ MINERAL/ HERBAL SUPPLEMENTS AND MEDICATIONS

Medication	Reason	Duration of Treatment

SLEEP HABITS

Please indicate any of the following symptoms that describe your sleep habits:

SLEEP HABITS	YES	NO	FREQUENCY
Snore, gasp, stop breathing			
Fight off sleep while driving			
Fight off sleep while reading			
Fight off sleep while watching TV			
Fight off sleep while working			
Have trouble falling asleep			
Have trouble staying asleep			
Wake up and cannot fall back asleep			
Experience daytime fatigue			
Does your bed partner complain of your snoring?			

Have you been diagnosed with sleep apnea? YES NO

When were you diagnosed? ______________________

Is it currently treated? YES NO How? __________________

Do you use a CPAP machine? YES NO If YES, how many hours per night? __________

How many hours do you sleep per night? ___________________

PERSONAL LIFESTYLE

Please list current major stressors/ obstacles to daily living:

____

____

Describe how you spend your leisure time:

____

____

Describe your exercise activities:

____

____

How healthy would you describe your daily diet?

____

____

PERSONAL DIET CONSIDERATIONS

How often do you consume the following items?

	DAILY	WEEKLY	MONTHLY	NEVER
Alcohol				
Caffeine				
Spicy Foods				
Tobacco				

List your food intake for the last three days:

BREAKFAST LUNCH DINNER SNACK

1 ____

2____

3____

PERSONAL SYMPTOM SURVEY

Please rate from 1 (never) to 5 (most severe) the following symptoms

Symptom	1	2	3	4	5	How Often?	Daily	Weekly	Monthly
Anxiety									
Bloating									
Depression									
Fuzzy Thinking									
Headache									
Incontinence									
Low sex drive									
Moodiness									
Swollen Breasts									
Cramps									
Emotional Swings									
Painful Breasts									
Early Menstruation									

Symptom	1	2	3	4	5	How Often?	Daily	Weekly	Monthly
Headache									
Heart Palpitations									
Hot Flashes									
Insomnia / Sleep Disturbances									
Night Sweats									
Painful Intercourse									
Shortness of Breath									
Short Term Memory Loss									
Tearfulness									
Vaginal Dryness									
Dry Skin									
Inability to Reach Orgasm									
Lack of Menstruation									

Symptom	1	2	3	4	5	How Often?	Daily	Weekly	Monthly
Breast Swelling									
Cold Hands/ Feet									
Cravings for Sweets									
Fatigue									
Fibrocystic Breasts									
Water Retention									
Weight Gain									

PERSONAL SYMPTOM SURVEY (CONTINUED)

Please list any other bothersome symptoms which you would like to address:

____

____

____

Which three symptoms would you like to fix as soon as possible?

____

____

____

What are your personal goals with taking BHRT?

____

____

____

What is the best way for us to contact you? (Phone, email, etc.)

____

May we send you information via email? YES NO

May we leave you a voice mail? YES NO

Signature: ____ **Date:** _______________

Print: _________________________________

QUESTION DOCUMENTATION FORM

Please write down any questions you may have about prescription Bio-Identical Hormone Replacement Therapy (BHRT), other medications, or any other questions that come up as you read through the materials you have received. Please bring this question sheet with you to your consultation so that you can discuss this information with your pharmacist. Thank you!

1.

2.

3.

4.

5.

Frequently Asked Questions

Q. When will I be contacted after submitting all of the materials?

A. At Jayhawk we make every effort to expedite the evaluation process, but it is not uncommon to wait two (2) weeks before your questionnaire is thoroughly evaluated by our BHRT specialists. Once this is completed, we will contact you to schedule your in-person consultation. After the consultation, a formal assessment and plan with therapy recommendations will be sent to your doctor. Once authorization from your doctor is received, you will be contacted about your recommended treatment regimen and your custom prescriptions will be compounded here in our lab.

Q. After my initial treatment regimen how am I monitored?

A. Our staff is always available for questions during normal business hours via phone call or email. During the initial weeks and months of therapy, feedback and communication is encouraged and frequent. Monitoring from that point on will be annual or as needed.

Q. How long before I notice symptomatic relief?

A. Symptomatic relief varies depending on the symptom and specific hormone regimen; anywhere from a few days to several weeks in certain situations.

Q. Are there any side effects?

A. As with any medication there is always a possibility of side effects. We will consult you on these possibilities and how to remedy them.

Q. What dosage forms do you provide?

A. Bio-Identical hormones are most commonly compounded into capsules, creams, and oral lozenges. Working with you and your physician, we will determine the most appropriate and convenient dosage form for you.

Q. Is the assessment and evaluation fee covered by my insurance?

A. No. The cost of the 1-hour consultation appointment is $150. This covers the cost of the appointment, as well as the time necessary to evaluate/formulate a BHRT regimen, in addition to our follow up consultations with you.

Q. Are the prescriptions covered by my insurance?

A. Depending on your individual insurance plan, coverage will vary. All patients pay up front for their medications, and we always provide a Universal Claim Form with your prescriptions that you may submit to your insurance provider. Your insurance provider will then reimburse you if any or all of your medication is covered.

Q. Do I need blood or saliva tests?

A. A saliva test (for hormone levels) is preferred, but a blood test works as well. Treatment recommendations are made based on the full clinical picture, including, but not limited to: test results, symptoms, and past medical history.