Customized Hormone Replacement Therapy Evaluation For Women

Figure 4. Steroidogenesis pathways

Customized Medication Compounding (USP 795) • Medication Therapy Management Botanical and Nutraceutical Medicines • Sterile Products Laboratory (USP 797) Proud Compounding Pharmacy of the Cleveland Indians
Suggested Lab Work for Women

Blood or saliva levels of hormones can be helpful in evaluating your replacement needs. We suggest that you have your physician get a base-line level of your hormones before starting hormone replacement therapy. Although it is not absolutely necessary to have this information for your physician and the pharmacist to complete your evaluation, it is often helpful. The lab tests may consist of drawing up to 8 vials of blood, and may be expensive if you do not have insurance. There are also saliva labs that may be drawn, but may not be covered by your insurance. You may want to discuss this with your physician prior to starting your therapy. The suggested ICD-10 may be any of the following: E34.9 – Endocrine disorder, unspecified; N95.1 – Menopausal and female climacteric states; E27.8 – Other specified disorders of the adrenal gland.

The following labs are what we suggest you have drawn. If not all are affordable, please let us know and we will suggest which labs would be best to draw based on your completed evaluation.

These labs should be drawn in the morning between 7:00-9:00, fasting, before taking your morning medications and supplements. If you are still having a monthly cycle, you should have the labs drawn on the 21st day of the cycle (day 1 of the cycle is the first day of bleeding).

Your physician may also want to draw thyroid labs. Suggested ICD-10 E03.8 – Other specified hypothyroidism. If they do, we suggest the following complete panel: TSH, T3 Total, T3 Free, T4 Total, T4 Free, Reverse T3, thyroglobulin, thyroglobulin antibody, thyroid peroxidase antibody, ferritin and serum serotonin.

Consider fasting insulin, glucose, hemoglobin A1C, and C-peptide labs if you suspect Metabolic Syndrome or other blood sugar imbalances. Other cardiovascular labs such as a cholesterol panel, C-reactive protein, homocysteine and Lipoprotein (a) may also be helpful. Suggested ICD10 – E78.2 Mixed hyperlipidemia.
Buderer Drug offers an ongoing consultation service for patients who are receiving customized hormone replacement therapy. A one-time consulting fee of $65.00 will be charged to you when you start customized hormone replacement therapy. This fee covers all services you receive with our expert pharmacists, including: initial work-up, consultations with you and your physician, continuing follow-up of your progress, and future therapy modification consultations with your physician. This one-time fee is all you’ll pay so long as Buderer Drug maintains your hormone replacement prescription. We will provide you with a medical receipt for insurance purposes. Please be advised that your insurance may or may not pay for some or all of your prescription and consultation. Any charges not covered by your insurance will be your responsibility. We look forward to serving and caring for you.

Effective 8-05
Customized Hormone Replacement Confidential Evaluation

From a clinical management point of view, it is very useful to gain a detailed history of possible hormone deficiencies. The answers provided to questions in this form will allow us to maintain your medical history and will help in advising about current medical therapies. All information provided will be kept confidential. The pharmacist will evaluate this form. When complete, please give the form, as well as any lab work to the pharmacist or the physician or nurse practitioner and have it faxed to the pharmacy. Please call the pharmacy to schedule a phone or face-to-face appointment.

GENERAL INFORMATION

Name: ___________________________  Age: _______ Birthdate: ______________

Address:__________________________________________________________________________________________

City, State Zip:______________________________________________________________________________________

Home Phone: __________________;  Work Phone: __________________;  FAX: _________________________________

Occupation: ______________________  Full-Time __;  Part-Time __;  Retired __;  Unemployed __;  Other: __

Living Situation: Spouse __;  Alone __;  Partner __;  Friend(s) __;  Parents __;  Children __;  Other __

Marital Status: Married ____;  Single ____;  Separated ____;  Divorced ____;  Widowed __

Pets: __________________________________ Indoors?_______________ Bedroom?___________________________

How did you hear about Natural Hormone Replacement Therapy?

Ad ___;  Another Patient ___;  Courses/Seminars ___;  Physician/Healthcare practitioner ___;  Books/Articles ___

Other __________________________________________

Who referred you to us? __________________________________________

Do you understand what Natural Hormone Replacement is? ________________________________

What is your greatest need or problem today? (List the most important; then list four other issues in order of importance): ___________________________  _________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
INSURANCE and PHYSICIAN INFORMATION

We will be glad to assist you in filling out your insurance claim forms if we are not able to transmit your prescription on-line. Payment is due in full at the time services are rendered.

Your SS#:______________________

Prescription Insurance Company: ____________________________________________________________

Cardholder’s Name: ___________________________ Birthdate: ____________________________

Is address same as yours?  Y  N  If no, give Cardholder’s Full Address and Telephone: __________________________

Employer: ___________________________ Cardholder’s SS#: ___________________________ Sex: Male  Female

Cardholder’s ID#: ___________________________ Prescription Plan #: ___________________________ Group #: ________

Your relationship to Cardholder: Self  Spouse  Other: _____________  Miscellaneous: ____________________________

Which Health Care Provider (physician, midwife, etc.) should we contact concerning this consult?

__________________________________________________________________________________________

When was your last appointment with this Health Care Provider? ____________________________

Other Current and Recent Health Care Providers: ____________________________________________

__________________________________________________________________________________________
MEDICAL STATUS

How do you rate your general health? Excellent; Good; Fair; Poor. Height: ____ ft. ____ in.; Weight: ______ lbs.

Blood Type: ______________ Blood pressure: ______________ Pulse: ______

Your current medical conditions or diagnoses: ____________________________________________________________

Drug Allergies: ___________________________________________________________________________________

Allergies to Food, Pollens, Environment, etc: __________________________________________________________

Names of ALL Prescription Medications, taken in last 6 months. Include strength and how you take them:

_________________________________________________________________________________________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

Have you taken any Herbal Products: Evening Primrose Oil (EPO), Chaste Tree Berry, Dong Quai, Black Cohosh

Ginseng, Melatonin, etc):   Y   N

Names of products: ________________________________________

Names of ALL Vitamins, Supplements, Non-Prescription medicines, or other OTC products that you are currently using:

_________________________________________________________________________________________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

Are you currently taking medication for a thyroid condition?   Y   N   Which one and Dose?______________________

How many times has your thyroid dosage been adjusted in the last year? _____ If you know your most current labwork,

enter it here:   TSH_____   T4_____   T3_____   rT3_____   TBG_____   Thyroid peroxidase antibody ______

Have your blood lipid (cholesterol/triglyceride) levels been checked recently?   Y   N   When? _____________ Results:

Cholesterol (TC) ________ Triglycerides_______ HDLC_______ LDL_______ VLDL_______ Chol/HDL C_______

How often are your bowel movements: _____/day OR _____/week.

Do you suffer from frequent constipation, irritable bowel, colitis, diarrhea or frequent bowel movements?   Y   N

Please give details:__________________________________________________________________________________

_________________________________________________________________________________________________
Your body type may influence your hormone therapy. Please choose 1 or more body types which are most similar to your own. (Most women are a combination of 2 types.)

ANDROID TYPE: The android type is characterized by a boyish, strong, sometimes thickset, skeletal frame, broad shoulders, a wide rib cage, muscular limbs, and a somewhat thick waist. If excess weight gain occurs, fat is deposited first in the upper part of the body, above the pelvis — resulting in thickening of the neck, torso, waist, and abdomen — the pattern is sometimes called “apple-shaped obesity.”

GYNECOID TYPE: Characterized as a pear shape, with the buttocks and thighs flowing outwards below a narrow waist. Buttocks are curved and rounded, and the thighs curve out to the sides. The shoulders are small to average in breadth; the waist is tapered and much smaller than the hips; and the pelvis is wide. The bones of the limbs are slender, with tapered, fine forearms, wrists, shins, and ankles. If weight gain occurs, occurs, fat is deposited first on the buttocks, thighs, and breasts, and later over the lower abdomen in front of the pubic bones. If weight gain occurs, the bottom has a tendency to droop downward over the backs of the thighs.

LYMPHATIC TYPE: Characterized by a generalized thickening and puffiness of the tissues underlying the skin. Gains weight very easily; often chubby since childhood. Retains lymphatic fluid and fat, especially in the limbs, resulting in thick arms and legs, with a straight up and down look along their length. Ankles and wrists are thick and puffy in appearance. Shoulders, breasts, and rib cage are average in size; abdomen may protrude in front. Torso is relatively straight up and down, with a thick waist and moderate curves outward on the buttocks and thighs. Bones and muscles are average in size; their shape is not clearly defined. When weight is gained fat is deposited all over the body in the legs, feet, arms, hands, buttocks, abdomen, trunk, neck, and face.

THYROID TYPE: Small bones, long limbs, narrow waist, with small outward curvature to buttocks & thighs; long and narrow fingers, toes, and neck; bone structure clearly defined; ribs and bony protuberances (knobs) around the joints being very evident. If weight gain occurs, fat is deposited around the abdomen and upper thighs, while the upper part of the body and limbs remain slim. Thyroid-type women gain weight less easily than the other body shapes.
BODY TYPE: Do you gain weight easily? Y N Please select (from the BODY TYPE PAGE in this document) one of the following body types which best describes how your body handles weight gain (some people may be a mixture of two types). Circle the best choice after reviewing pictures: ANDROID GYNECOID LYMPHATIC THYROID

Please close the ring finger and thumb of one hand around your other wrist. Do the ring finger and thumb touch? Y N

Have you ever had a bone density scan? Y N When? ___________; Results: _______________________ 


Do you use caffeine products? Y N What: ____________; How Much: ____________________

Do you use recreational drugs? Y N What: ____________; How Much: ______________________

How much water do you drink in one day (24 hr)? ________ oz. ________ glasses Is your drinking water from a:

___home well ___city water ___distilled water ___bottled water ___ water purifier ___________________

Dietary Restrictions (such as salt, carbohydrates, milk products, red meat, etc): ________________________________

Please list your Typical Food Choices:

Breakfast: __________________________________________________________________________________

Lunch: _________________________________________________________________________________________

Dinner: _______________________________________________________________________________________

Snacks: _______________________________________________________________________________________

Please circle applicable Food Cravings: None Sweets Salts Chocolate Other: ______________________________

Do you get routine Physical Exercise? IF YES, then what type? ________________________________

How long per day? ______minutes/day and/or ______hours/day; How many days per week: ____days.

What is your average heart rate when you are exercising? _______

SLEEP: How long does it take you to fall asleep? Minutes: 5 10 15 30 60+ How many hours of sleep do you get per night? ________hours Do you sleep uninterrupted all night? Y N If No, how many times do you awaken? ________ times. Do you awaken at a particular time(s)? ___________ What awakens you? ____________

Do you dream? Y N If Yes, do you remember your dreams? Y N

Do you nap during the day? Y N How often and how long do you nap? ________________________________
PAST MEDICAL CONDITIONS

List your Childhood Diseases:

__________________________________________________________________

__________________________________________________________________

PERSONAL & FAMILY HISTORY:  (You, your parents, brothers, sisters, and grandparents. Please list whom in the details section.)

Alzheimer's Disease? Y Details _______________________________________________________
Asthma? Y Details _______________________________________________________
Anemia? Y Details _______________________________________________________
Eating Disorder? Y Details _______________________________________________________
Depression? Y Details _______________________________________________________
Headaches? Y Details _______________________________________________________
Epilepsy? Y Details _______________________________________________________
Dry, Coarse Skin Y Details _______________________________________________________
Prematurely Gray? Y N Who/When _____________________________________________
Thyroid Problem? Y Details _______________________________________________________
Osteoporosis/Osteopenia? Y Details _______________________________________________________
Fractures (broken bones)? Y Details _______________________________________________________
Arthritis? Rheumatoid Osteo Y Details _______________________________________________________
Diabetes? IDDM NIDDM Y Details _______________________________________________________
Lupus? Y Details _______________________________________________________
Kidney Disease? Y Details _______________________________________________________
Pancreas Disease? Y Details _______________________________________________________
Fibromyalgia? Y Details _______________________________________________________
Chronic Fatigue Syndrome? Y Details _______________________________________________________
Mitral Valve Prolapse? Y Details _______________________________________________________
Heart Trouble? Y Details _______________________________________________________
High Blood Pressure? Y Details _______________________________________________________
Stroke? Y Details _______________________________________________________
Blood Clotting Disorder? Y Details _______________________________________________________
Varicose Veins? Y Details _______________________________________________________
High Cholesterol? Y Details _______________________________________________________
High Triglycerides? Y Details _______________________________________________________
Gall Bladder Trouble? Y Details _______________________________________________________
Liver Disease or Hepatitis? Y Details _______________________________________________________
Irritable Bowel or Colitis? Y Details _______________________________________________________
Decreased Vision, Blindness or Retinal Problem Y Details _______________________________________________________
Fibrocystic Breasts? Y Details _______________________________________________________
Breast Cancer? Y Details _______________________________________________________
PMS? Y Details _______________________________________________________
Ovarian Cysts/Polycystic Ovaries? Y Details _______________________________________________________
Uterine Fibroids? Y Details _______________________________________________________
Endometriosis? Y Details _______________________________________________________
Polyps? Y Details _______________________________________________________
Abnormal Pap Smear? Y Details _______________________________________________________
Interstitial Cystitis? Y Details _______________________________________________________
Pelvic Inflammatory Disease (Chronic)? Y Details _______________________________________________________
Cancer of Cervix or Uterus? Y Details _______________________________________________________
Cancer (any other type) Y Details _______________________________________________________

Page 8 of 16
GYNECOLOGICAL

When was your last:  General medical exam: _________________ Pelvic exam:______________________

Have you ever had an Abnormal Pap?  Y   N   When? __________  Treatment: ______________________________

At what age was your First Period (menarche)? ________

When was your Most Recent or Last Period (LMP): ________

Do you still have your period?  Y   N

If Yes, how many days from the start of one period to the start of the next? _______days

Number of days of flow: ________

Amount of days of bleeding: ________________________________

Describe any cramping or pain you may have: ____________________________________________________________

Do you have pain at any other time in your cycle (eg: at ovulation)?  Y   N   Where, when, how long?__________

Any current changes in your normal cycle? ________________________________________________________________

Any bleeding between periods (IMB): ______________________ When and describe:______________________________

What were your periods like as a teenager?  ______________________________________________________________

____________________________________________________________

Have you ever had Premenstrual Symptoms? ______________________________________________________________

____________________________________________________________

Starting and ending when: ______________________________________

____________________________________________________________

How long have you had PMS symptoms? ________________________________________________________________

Have your periods ever been difficult, irregular, or abnormal in any way?  Y   N   How? ________________________

____________________________________________________________

____________________________________________________________

Are you currently having any pelvic pain, pressure, or fullness?  Y   N   Describe ______________________________

____________________________________________________________

____________________________________________________________

Any recent unusual vaginal discharge or itching:  Y   N   Describe: _________________________________________

____________________________________________________________

Treatment: ________________________________________________________________________________________
Have you had any of the following surgeries?

- Tubes tied (tubal ligation)?
  - Y   N
  - When? __________ and at what age? __________

- Uterus removed (hysterectomy)?
  - Y   N
  - When? ________ Why? _____________________________

- Ovaries removed (oophorectomy)?
  - Y   N
  - PART If Yes or PART, What: _____________________________
  - When: __________ Why? _____________________________

- Were there any problems associated with the surgery or removal of any of these organs? _____________________________

Has your doctor diagnosed menopause, or told you that you are in menopause? Y   N
- If Yes, at what Age? __________

If at age 40 years or earlier, was Premature Ovarian Failure diagnosed? Yes   No

Have you ever been pregnant? Y   N
- Are you trying to get pregnant? Y   N
  - What was your age at your first pregnancy? ________ Any problems? _____________________________

How many times have you been pregnant (gravid)? ________ How many pregnancies resulted in the birth of living children (para)? ________ Were there any problems? _____________________________

Any interrupted pregnancies (miscarriages or abortions)? _____________________________

How much did your babies weigh at birth? __________________________________________________________________________

Current birth control method: _____________________________ How long: _____________________________
- Any problems? _____________________________

Have you ever used any of the following birth control methods:

- Oral Contraceptives (Birth Control Pills) Y   N
  - Total months/years used: _____________________________

- Have you ever had any side effects to Birth Control Pills? Y   N
  - What side effects? _____________________________

- Intra-Uterine Device (IUD) Y   N
  - Problems? _____________________________

- Spermicde/Barrier (foam, jelly, suppository, diaphragm, condom) Y   N
  - _____________________________

When was your last mammogram? ________ Results: __________ Do you examine your breasts monthly? Y   N

Have you ever experienced breast pain, discomfort, nipple discharge, or swelling other than when pregnant? Give details:

___________________________________________________________________________________________

Have you ever been diagnosed with lumps, fibroids, breast cancer, or similar breast conditions?

___________________________________________________________________________________________

Has your doctor ordered any lab tests or diagnostic procedures for you recently? Y   N
- Did you have the diagnostic procedure or lab performed? Y   N
  - Please give details: _____________________________

___________________________________________________________________________________________
SEXUAL

Are you sexually active now?  Y  N  If No, is that a problem for you?_____________________________

If you were rating the sexual part of your life on a schedule of 1 to 10, where would you put it? (10 = excellent)

1 2 3 4 5 6 7 8 9 10

What would you change about it, if you could? ___________________________________________________________
_________________________________________________________________________________________________

Do you have any problems with sexual desire? _________________________
______________________________________________________________

Frequency? _______________________________________________________

Arousalability? ____________________________________________________

Orgasm (Do you usually climax)?  Y  N  If No, is that a problem for you? _______________________________

Pain?  Y  N  _______________________________________________________

Do you have any pain at the beginning of, during, or after having sex?_____________________________________
____________________________________________________________________________________________

Are you experiencing vaginal dryness?  Y  N  If Yes, when did you first notice it? _______________________

Have you experienced a Loss of sexual sensitivity:

Of the nipples?  Y  N

Of the clitoris?  Y  N

Have you noticed any changes in your Body Hair Patterns? _________________________________________________
______________________________________________________________________________________________

Have you lost any pubic hair?  Y  N  If Yes, when did you first notice it?_______________________________

Has your sex life changed significantly in the past few years?  Y  N

If Yes, how? ________________________________________________________________
____________________________________________________________________________________________

Do you think there is anything your partner would like to change? ________________________________________
_____________________________________________________________________________________________

Is there anything you can think of that we have not covered and that may be important to your sexual life? ______
______________________________________________________________________________________________
                                                                                                           

<table>
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<th>Symptom</th>
<th>Trend</th>
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<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Your Comments</th>
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<td>Depression</td>
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<td>0</td>
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<td>Unloved Feelings</td>
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<td>2</td>
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<tr>
<td>Anxiety/Tension/Nervousness</td>
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<td>Mood Swings/Mood Changes</td>
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<td>Crying Easily</td>
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<td>Angry Outbursts/Arguments/ Violent Tendencies</td>
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<td>2</td>
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<td>Joint Pains</td>
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<td>2</td>
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<tr>
<td>Muscle Pains</td>
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<td>0</td>
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<td>2</td>
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<tr>
<td>Dry Skin/Dry Hair</td>
<td></td>
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<td>2</td>
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<td></td>
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<tr>
<td>Crawling Feeling Under Skin</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>
CIRCLE A NUMBER FOR EACH SYMPTOM which best describes how you have been feeling for the past 3 weeks.

0 = None (symptom not present)
1 = Mild (present but not distressing)
2 = Moderate (distressing, but not interfering with daily life)
3 = Severe (very distressing, interferes with daily life)

<table>
<thead>
<tr>
<th>Trend</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
</table>

Frequent UTI/Vaginal infections

Urinary frequency/Urinary Incontinence

Dry vagina

Uncomfortable intercourse

Loss of Sexual Feeling/Desire

Loss of Arousability & Capacity for Orgasm

Loss of Sexual Sensitivity: Clitoris

Nipples

Loss of Pubic Hair

Any Recent Change in Body Hair Patterns

Forgetfulness/Short Term Memory Loss

Confusion/Difficulty Concentrating

Heart Palpitations

Shortness of Breath

Discharge or Leaking from Nipples

Breast Tenderness
### CIRCLE A NUMBER FOR EACH SYMPTOM

Which best describes how you have been feeling for the past 3 weeks.  

<table>
<thead>
<tr>
<th></th>
<th>Trend</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Your Comments</th>
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<tr>
<td>Pelvic pain, Pressure, Fullness, or Bloating</td>
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<td>0</td>
<td>1</td>
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<td>3</td>
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<tr>
<td>Swelling of Hands, Ankles, or Breasts</td>
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<td></td>
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<tr>
<td>Food Cravings /Sweets / Salts</td>
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<td>Increased appetite/Weight Gain</td>
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<td>Loss of Vital Energy (Vitality)</td>
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<td>Acne/Pimples/Skin Flushing</td>
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<td>New Facial Hair</td>
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<td>Tightness in neck/shoulders</td>
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<td>Visual Disturbance or Decreased Vision</td>
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<td>Difficulty Hearing</td>
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<td>Diminished sense of taste</td>
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<td>3</td>
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<tr>
<td>Diminished sense of smell</td>
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<tr>
<td>Problems with wound healing time</td>
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<td>2</td>
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<tr>
<td>Muscle cramps/spasms</td>
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<td>2</td>
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</tr>
</tbody>
</table>

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2 = Moderate (distressing, but not interfering with daily life)  
3 = Severe (very distressing, interferes with daily life)
Females Only: Do you still have your ovaries?  Y  N  Do you still have your period?*  Y  N  If yes, when was your last period?  Date period started: __________  Date period ended: __________  If no, are you taking any hormones?  Please list hormone names and dosage schedules:_____________________________________________________________________

*Note:  For women who still have their periods, the temperature should be taken starting the second day of bleeding.  If you miss a day, that is OK, but be sure to finish before ovulation.  For men, and for women who are menopausal, it makes no difference when the temperatures are taken.  However, do not do the test when you have an infection or any other condition that would raise your temperature.

### TEMPERATURE LOG

<table>
<thead>
<tr>
<th>ENTER DATE &gt;</th>
<th>TAKE YOUR TEMPERATURES AT:</th>
<th>LOCATION TO TAKE AT:</th>
<th>ON FIRST DAY</th>
<th>ON SECOND DAY</th>
<th>ON THIRD DAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Awaking (within 10 minutes)</td>
<td>Under Tongue</td>
<td></td>
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<tr>
<td>2. Mid-day</td>
<td>Under Tongue</td>
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<tr>
<td>3. Evening</td>
<td>Under Tongue</td>
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<tr>
<td>4. Bedtime</td>
<td>Under Tongue</td>
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</tbody>
</table>

This log will help determine your basal temperature and your average daily temperature. Since we want to do the best job possible in optimizing our health recommendations for you, it is important that you obtain the most accurate temperature readings possible by carefully following the temperature-taking procedure outlined below:

**PROCEDURE:**

1. Use any thermometer available but note the type used.  Be sure to "sling" the mercury down to 96° F. prior to using the old type thermometers.

2. Sling the mercury down each night before going to bed, if you have this kind.

3. In the morning, as soon as you wake up, put the thermometer under your tongue, then record the temperature in the proper space on the chart.  Do this before you get out of bed, have anything to eat, drink, or engage in any activity.

4. Take the next 3 temperatures during the day.

5. Record the temperatures on lines 1 through 4 of the Temperature Log chart provided above.
   - Be sure to record the exact temperature, including the tenth of a degree even if it is an even number.
   - Example: 97.2°, 98.0°, etc.

What type of thermometer did you use? __________________________________________________________
Patient Consult from Buderer Drug Co.

Name: ___________________________  DOB: ___________  Date: ________________

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