David Arnold 1848-1925
Henry Henkelman 1860-1931
John Bechberger 1866-1950
Nicholas Brown 1881-1971
Rolland Kubach 1894-1961
Alvin Buderer 1906-1966
Kenneth Watson *dec.*

Buderer Drug Co.

633 Hancock Street • Sandusky, Ohio 44870
419-627-2800 • 800-259-6662 • Fax 419-626-0494
*26611 N. Dixie Highway, Suite 119 • Perrysburg, OH 43551
419-873-2800 • 800-318-3408 • Fax 419-873-0494
38530 Chester Road, Suite 400 • Avon, OH 44011
440-934-3100 • 866-697-1231 • Fax 440-934-3103

Est. 1878

James W. Buderer, R.Ph., President
Matthew J. Buderer, R.Ph., FIACP, Vice President

Customized Hormone Replacement Therapy Evaluation For Women

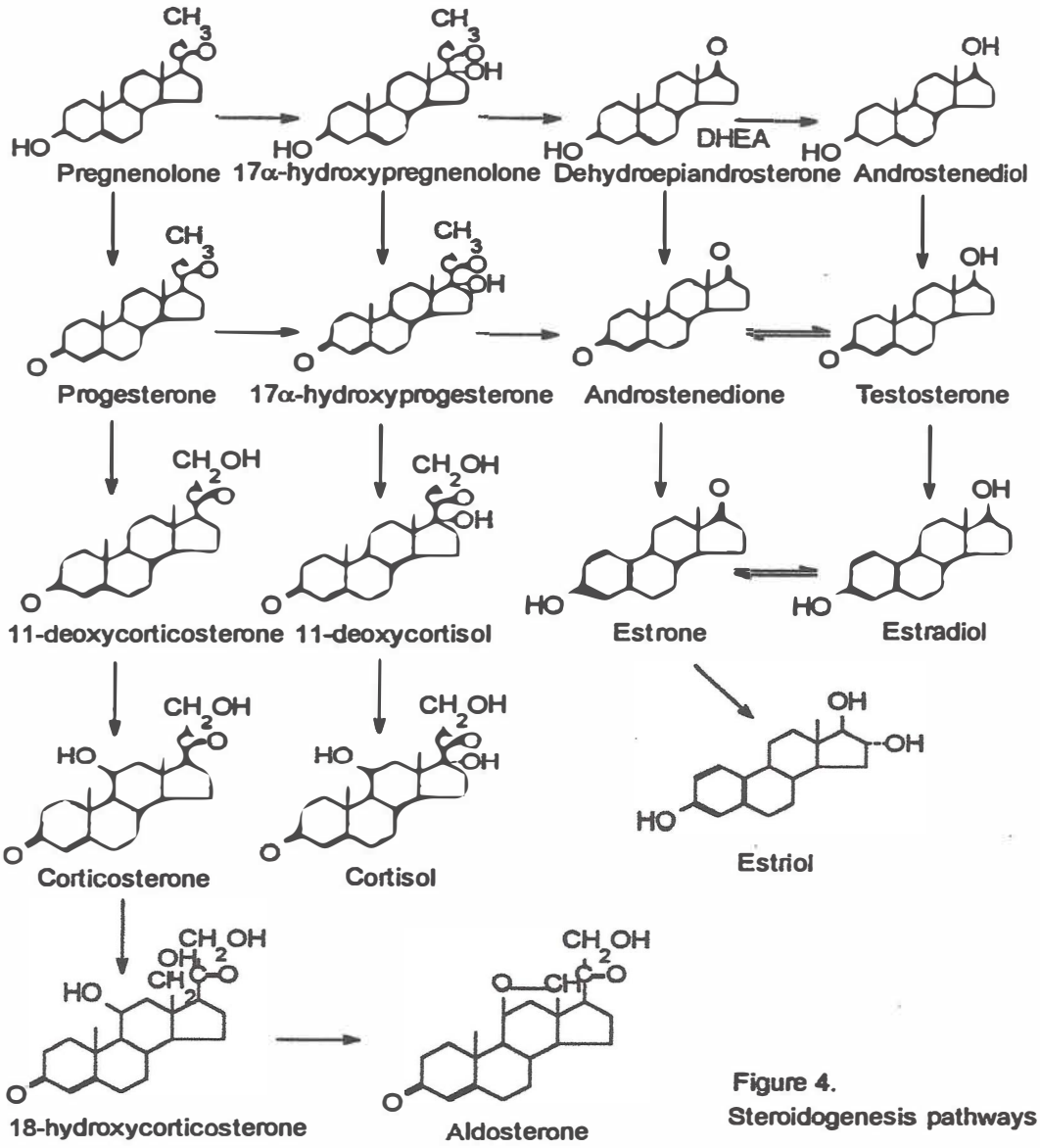
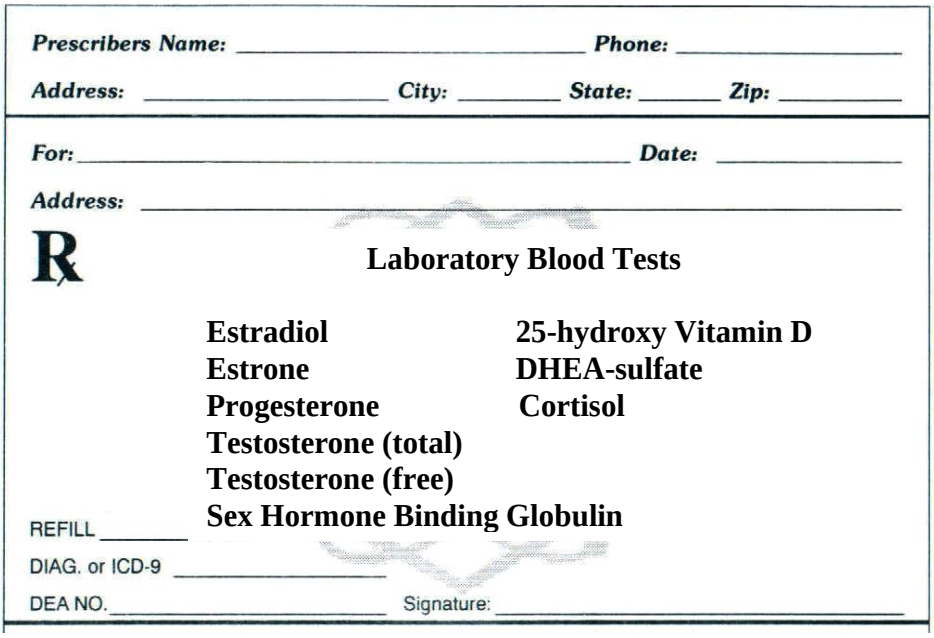


Figure 4.
Steroidogenesis pathways

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.



Prescribers Name: _____ *Phone:* _____

Address: _____ *City:* _____ *State:* _____ *Zip:* _____

For: _____ *Date:* _____

Address: _____

R

Laboratory Blood Tests

Estradiol
Estrone
Progesterone
Testosterone (total)
Testosterone (free)
Sex Hormone Binding Globulin
25-hydroxy Vitamin D
DHEA-sulfate
Cortisol

REFILL _____

DIAG. or ICD-9 _____

DEA NO. _____ Signature: _____

Additional Labs:

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

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Est. 1878

CONSULTANT PHARMACIST AGREEMENT

for

New Patients Starting Customized Hormone Replacement Therapy

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

BUDERER DRUG CO.

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38530 Chester Rd. #400 Avon, Ohio 44011 440-934-3100 fax: 440-934-3103

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

DATE: _____

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 PHYSCIAN 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_____ T_4 _____ T_3 _____ rT_3 _____ 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/HDLC_____

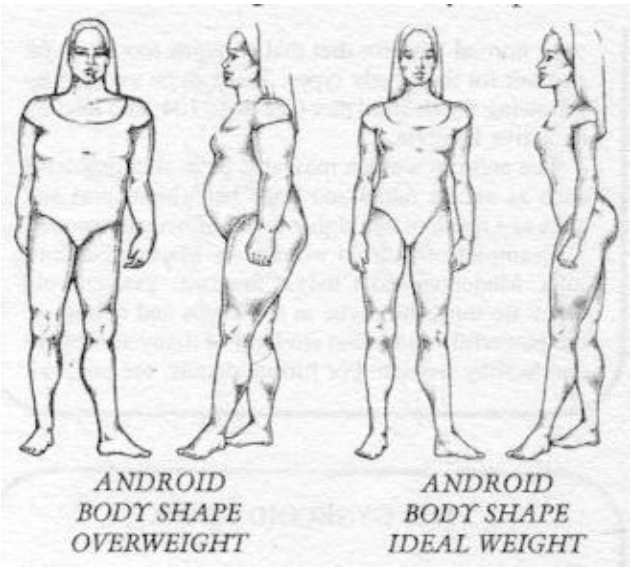
How often are your bowel movements: _____/day OR _____/week.

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

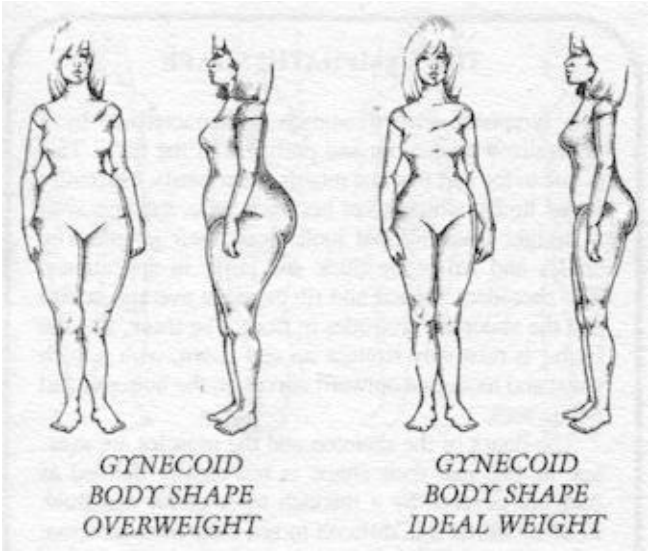
Please give details:_____

_____

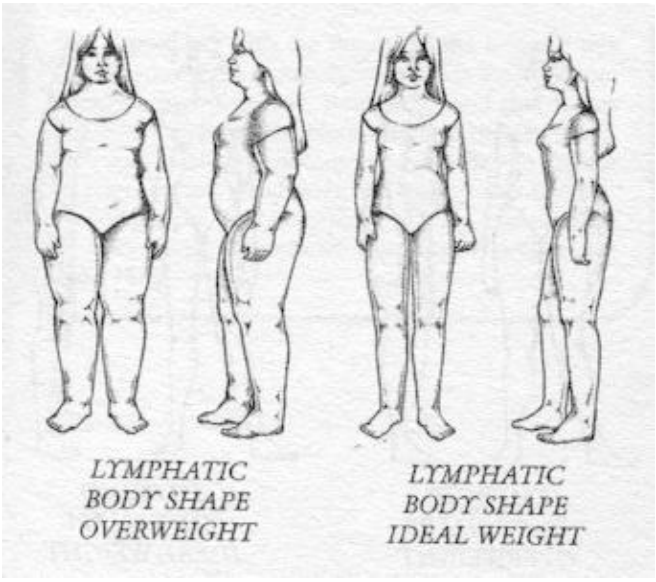
Your body type may influence your hormone therapy. Please choose 1 or more body types which are most similar to your own. (Most women are a combination of 2 types.)



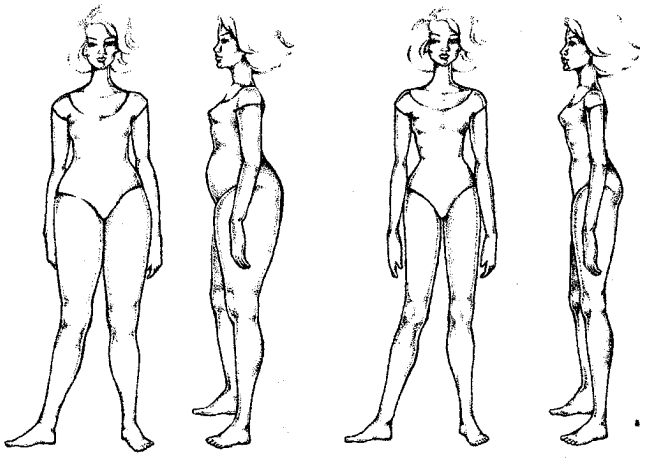
ANDROID TYPE: The android type is characterized by a boyish, strong, sometimes thickset, skeletal frame, broad shoulders, a wide rib cage, muscular limbs, and a some-what thick waist. If excess weight gain occurs, fat is deposited first in the upper part of the body, above the pelvis -- resulting in 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 tobacco products? Y N What: _____; How Much: _____; For How Long: _____

Do you use alcohol products? Y N What: _____; How Much: _____; For How Long: _____

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 Y Details _____
or Retinal Problem _____
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 _____

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 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 (gravida)? _____ 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? _____

Spermacide/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? _____

Arousability?_____

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? _____

_____

_____

_____

CIRCLE A NUMBER FOR EACH SYMPTOM which best describes how you have been feeling for the past 3 weeks.

0 = None (symptom not present) **2 = Moderate (distressing, but not interfering with daily life)**

1 = Mild (present but not distressing) **3 = Severe (very distressing, interferes with daily life)**

	Trend	None	Mild	Moderate	Severe	Your Comments
Hot flushes		0	1	2	3 →	
Night Sweats		0	1	2	3 →	
Light-headed Feelings/Dizziness		0	1	2	3 →	
Headaches		0	1	2	3 →	
Sleep Disorders/Sleeplessness		0	1	2	3 →	
Unusual Tiredness/Fatigue		0	1	2	3 →	
Irritability		0	1	2	3 →	
Depression		0	1	2	3 →	
Unloved Feelings		0	1	2	3 →	
Anxiety/Tension/Nervousness		0	1	2	3 →	
Mood Swings/Mood Changes		0	1	2	3 →	
Crying Easily		0	1	2	3 →	
Angry Outbursts/Arguments/ Violent Tendencies		0	1	2	3 →	
Backache		0	1	2	3 →	
Joint Pains		0	1	2	3 →	
Muscle Pains		0	1	2	3 →	
Dry Skin/Dry Hair		0	1	2	3 →	
Crawling Feeling Under Skin		0	1	2	3 →	

CIRCLE A NUMBER FOR EACH SYMPTOM which best describes how you have been feeling for the past 3 weeks.

0 = None (symptom not present) **2 = Moderate (distressing, but not interfering with daily life)**

1 = Mild (present but not distressing) **3 = Severe (very distressing, interferes with daily life)**

	Trend	None	Mild	Moderate	Severe	Your Comments
Frequent UTI/Vaginal infections ----------		0	1	2	3 →	
Urinary frequency/Urinary Incontinence		0	1	2	3 →	
Dry vagina		0	1	2	3 →	
Uncomfortable intercourse ----------		0	1	2	3 →	
Loss of Sexual Feeling/Desire		0	1	2	3 →	
Loss of Arousability & Capacity for Orgasm ------		0	1	2	3 →	
Loss of Sexual Sensitivity: Clitoris ----------		0	1	2	3 →	
Nipples		0	1	2	3 →	
Loss of Pubic Hair ----------		0	1	2	3 →	
Any Recent Change in Body Hair Patterns		0	1	2	3 →	
Forgetfulness/Short Term Memory Loss ----------		0	1	2	3 →	
Confusion/Difficulty Concentrating ----------		0	1	2	3 →	
Heart Palpitations		0	1	2	3 →	
Shortness of Breath		0	1	2	3 →	
Discharge or Leaking from Nipples ----------		0	1	2	3 →	
Breast Tenderness		0	1	2	3 →	

CIRCLE A NUMBER FOR EACH SYMPTOM which best describes how you have been feeling for the past 3 weeks.

0 = None (symptom not present) **2 = Moderate (distressing, but not interfering with daily life)**

1 = Mild (present but not distressing) **3 = Severe (very distressing, interferes with daily life)**

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

YOUR NAME: _____

DATE: _____

For Office Use:

Barnes Score: _____

Oral Score: _____

****** All Patients Complete this form. ******

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

ENTER DATE >				
TAKE YOUR TEMPERATURES AT:	LOCATION TO TAKE AT:	ON FIRST DAY	ON SECOND DAY	ON THIRD DAY
1. Awaking (within 10 minutes)	Under Tongue			
2. Mid-day	Under Tongue			
3. Evening	Under Tongue			
4. Bedtime	Under Tongue			

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:_____

Signature: **DEA #** **APRN#** **REFILLS:**

Please note: If you should have any questions concerning the suggested therapy for this patient, please contact our compounding pharmacist. If you should concur with some or all of these suggested therapies, please indicate which ones and then sign this sheet and fax it back to our lab. Only with your authorization will we put up the prescriptions for this patient.

Buderer Drug Co. fax: ☐ Perrysburg (419) 873-0494 ☐ Sandusky (419) 626-0494 ☐ Avon (440) 934-3103

I approve of the recommendations made and the evaluation of my patient in this consult.

CPT (99202) Evaluation. Related ICD-10: □ E34.9 – Endocrine disorder, unspecified; □ N95.1 – Menopausal and female climacteric states; □ E29.1 – Testicular hypofunction; □ N52.9 – Male erectile dysfunction, unspecified; □ E27.8 – Other specified disorders of the adrenal gland; □ E03.8 – Other specified hypothyroidism; □ E78.2 Mixed hyperlipidemia