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.

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.
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 $95.00 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 1-1-2022

***************************************************************************
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):

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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: _____________________________________________________________

Drugs 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 _______

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 tobacco 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.)

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

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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? __________________

Spermicide/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)  
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>Symptom</th>
<th>Trend</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hot flushes</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
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<tr>
<td>Night Sweats</td>
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<td>2</td>
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<td>Light-headed Feelings/Dizziness</td>
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<tr>
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<td>Unusual Tiredness/Fatigue</td>
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<td>2</td>
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<td>Irritability</td>
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<td>Depression</td>
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<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>Joint Pains</td>
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<td>Muscle Pains</td>
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<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>Dry Skin/Dry Hair</td>
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<td>2</td>
<td>3</td>
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<td>Crawling Feeling Under Skin</td>
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<td>2</td>
<td>3</td>
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<tr>
<td>Symptom</td>
<td>Trend</td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Comments</td>
</tr>
<tr>
<td>----------------------------------------------</td>
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<td>----------</td>
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<tr>
<td>Frequent UTI/Vaginal infections</td>
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<td>0</td>
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<td>Urinary frequency/Urinary Incontinence</td>
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<td>Dry vagina</td>
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<td>Uncomfortable intercourse</td>
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<td>Loss of Sexual Feeling/Desire</td>
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<td>2</td>
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<td>Loss of Arousability &amp; Capacity for Orgasm</td>
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<td>3</td>
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<td>Loss of Sexual Sensitivity: Clitoris</td>
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<tr>
<td>Nipples</td>
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<td>2</td>
<td>3</td>
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<td>Loss of Pubic Hair</td>
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<tr>
<td>Any Recent Change in Body Hair Patterns</td>
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<td>2</td>
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<tr>
<td>Forgetfulness/Short Term Memory Loss</td>
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<td>0</td>
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<td>2</td>
<td>3</td>
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<tr>
<td>Confusion/Difficulty Concentrating</td>
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<tr>
<td>Heart Palpitations</td>
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<td>Shortness of Breath</td>
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<td>2</td>
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<tr>
<td>Discharge or Leaking from Nipples</td>
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<tr>
<td>Breast Tenderness</td>
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<td>2</td>
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</tr>
</tbody>
</table>
**CIRCLE A NUMBER FOR EACH SYMPTOM** which best describes how you have been feeling for the past 3 weeks.

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

<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>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Mid-day</td>
<td>Under Tongue</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Evening</td>
<td>Under Tongue</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Bedtime</td>
<td>Under Tongue</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</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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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