Moss Compounding Pharmacy
2500 Hoffmeyer Road
Florence, SC 29501
843.665.0289

CONFIDENTIAL FEMALE HORMONE EVALUATION

Today's Date: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____
Street City State Zip

Phone: _____ Email: _____

Height: _____ Weight: _____ Desired Weight: _____

			How Often and how much?
Do you use tobacco?	☐ Yes	☐ No	_____
Do you use alcohol?	☐ Yes	☐ No	_____
Do you use caffeine?	☐ Yes	☐ No	_____
Do you exercise?	☐ Yes	☐ No	_____

Allergies: Please list any allergies and describe the reaction that occurred
Drugs: _____
Foods: _____
Other: _____

Over-the-Counter Medication History: Please list all non-prescription medications that you are taking. (Include vitamins, herbals, and supplements): _____
_____
_____
_____
_____
_____
_____

Medical Conditions/Diseases: Please list any conditions/diseases that you have been diagnosed with or suffer from. (Examples include: Heart disease, high blood pressure, depression, ulcers, arthritis, insomnia, etc).
_____
_____
_____

Current Prescription Medications (including hormones):

Medication Name and Strength	Date Started	How Often per day
_____		
_____		
_____		
_____		
_____		

Patient Name: _____

List Hormones Previously Taken: Date Started Date Stopped Reason

_____

_____

_____

_____

Have you ever used oral contraceptives (birth control)? ☐ Yes ☐ No

If you experienced any problems, please describe: _____

_____

How many pregnancies have you had? _____ How many children? _____ Your age at birth of 1st child _____

Any Interrupted pregnancies? ☐ Yes ☐ No

If yes, please explain:_____

Have you had a tubal ligation: ☐ Yes ☐ No If yes, date of surgery: _____

Have you had a hysterectomy? ☐ Yes ☐ No If yes, date of surgery: _____

Reason: _____ Do your ovaries remain? ☐ Yes ☐ No

Do you have a family history of any cancers or osteoporosis? Please list the family member(s):

_____

_____

_____

Have you had any of the following tests performed?

Mammography	☐ Yes ☐ No	Date: _____	Outcome: _____
PAP Smear	☐ Yes ☐ No	Date: _____	Outcome: _____
Bone Density	☐ Yes ☐ No	Date: _____	Outcome: _____

What age did your period start? _____ How many days is/was your cycle (Example: 28): _____

Is/was your menstrual flow heavy or light? _____ Any clots? ☐ Yes ☐ No

Have you ever had what YOU would consider to be abnormal cycles? ☐ Yes ☐ No

Explain: _____

_____

_____

When was your last period? _____ How many days did it last? _____

Do you or have you ever suffered from Premenstrual Syndrome (PMS) symptoms? ☐ Yes ☐ No

Explain: _____

_____

Name: _____

Do you have a medical history of any breast cancer or of ductal carcinoma in situ (DCIS) or lobular carcinoma in situ (LCIS) or has she received previous radiation therapy to the chest for treatment of Hodgkin lymphoma? Yes / No

Do you have a mutation in either the BRCA1 or BRCA2 gene, or a diagnosis of a genetic syndrome that may be associated with elevated risk of breast cancer? Yes / No / Unknown

Have you ever had a breast biopsy? Yes / No / Unknown

If yes, how many breast biopsies (positive or negative) have you had? _____

Have you ever had a breast biopsy with atypical hyperplasia? Yes / No

Are you currently receiving treatment for Hypertension (high blood pressure)? Yes / No

Are you currently receiving treatment for Diabetes? Yes / No

Vitals/Labs:

Most recent Blood Pressure readings (Date: _____)

Systolic Blood Pressure (in mm Hg) _____

Diastolic Blood Pressure (in mm Hg) _____

Most recent Lipid Panel labs (Date: _____)

Total Cholesterol _____

HDL ("good" cholesterol) _____

Patient Name: _____

	Absent	Mild	Moderate	Severe
Hot Flashes	_____	_____	_____	_____
Night Sweats	_____	_____	_____	_____
Vaginal Dryness	_____	_____	_____	_____
Incontinence	_____	_____	_____	_____
Bleeding Changes	_____	_____	_____	_____
Fibrocystic Breast	_____	_____	_____	_____
Weight Gain	_____	_____	_____	_____
Fluid Retention	_____	_____	_____	_____
Dry Skin/Hair	_____	_____	_____	_____
Hair Loss	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Mood Swings	_____	_____	_____	_____
Irritability	_____	_____	_____	_____
Headaches	_____	_____	_____	_____
Breast Tenderness	_____	_____	_____	_____
Cramps	_____	_____	_____	_____
Difficulty Falling Asleep	_____	_____	_____	_____
Difficulty Staying Asleep	_____	_____	_____	_____
Fatigue	_____	_____	_____	_____
Loss of Memory	_____	_____	_____	_____
Foggy Thinking	_____	_____	_____	_____
Acne	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Decreased Sex Drive	_____	_____	_____	_____
Harder to Reach Climax	_____	_____	_____	_____
Stress	_____	_____	_____	_____

Other: _____

_____

Patient Name: _____

What are your goals for taking Hormone Replacement Therapy?

1.
2.
3.

Doctor that we should contact for this therapy:

Name: _____ Phone: _____

Address: _____

Street City State Zip

*** Please include a copy of all relevant lab work, especially hormone levels that you have recently obtained.

MOSS COMPOUNDING PHARMACY
2500 Hoffmeyer Road, Florence, SC 29501
843.665.0289 (phone) / 843.667.9964 (fax)

Bioidentical Hormone Therapy Collaborative Care Program

When hormones are imbalanced, multiple aggravating symptoms can present. These symptoms typically include hot flashes, night sweats, insomnia, decreased libido, weight gain, hair loss, depression, and/or mood swings. When an appropriate dose and combination is initiated, hormone therapy is a very effective treatment option for these symptoms. The management of this process can be quite challenging because each patient presents with different symptoms and different hormone needs. In addition, there are numerous treatment options available including bioidentical hormones (those identical chemically to what is naturally found in the human body), non-bioidentical natural hormones (ie. equine estrogens), and synthetic/semisynthetic options. At Moss Compounding, we not only believe that hormone therapy must be customized for each individual patient's specific needs, but that bioidentical hormone therapy is the safest and most ideal manner to supplement hormones. We want to help you through this process and provide the most up-to-date information on hormonal health. Our consultants have been trained in the field of bioidentical hormone replacement therapy (BHRT) and receive annual ongoing education in this practice. We can work with your current prescribing health care provider to come up with a personalized plan for you.

In our program we require initial hormone testing and completion of an evaluation form before scheduling a consultation. These two important steps help the consultant determine an appropriate course and dosage of therapy. During the scheduled consultation, the pharmacist will review your medical history, current medications, symptoms, and dietary/lifestyle modifications to achieve the best results. After the consultation, the consultant will send a therapy recommendation to your current prescriber for approval. A licensed prescriber (ie. a medical physician, nurse practitioner, or physician assistant) can prescribe BHRT and will need to agree with the recommendation before any prescription medication is given.

The resolution of symptoms depends upon each patient's response to therapy. A medication or plan may need to be adjusted based on this response. Typically, a new recommendation cannot be justified until 4-6 weeks into a new therapy, for it takes that long for hormone levels to normalize. In some cases, additional testing (such as thyroid, vitamin D, cortisol and/or other levels) may be recommended.

Before requesting a consultation, please review the following policies and sign below acknowledging receipt.

Thank you for choosing us as your care provider for hormone therapy. We look forward to working with you.

Sincerely,

B. Bryan 379

Bryan Ziegler, PharmD, MBA

Moss Compounding Pharmacy
Bioidentical Hormone Therapy Collaborative Care Program
Fee Schedule & Office Policies

Hormone Testing

Moss Compounding Pharmacy recommends either serum or saliva testing of sex hormones at the initiation of therapy. For follow up testing, saliva testing may have advantages over serum testing depending on the dosage form used to deliver hormone therapy. In these cases, this option will be recommended for the most accurate evaluation of lab levels.

ZRT Saliva Test Kits are available for pick up at Moss Compounding Pharmacy. There is no charge to receive a kit. Payment for the selected lab will be made directly to ZRT Laboratory at the time of test ordering. We typically recommend the Female Saliva Profile I test, which tests the following: Estradiol (E2), Progesterone, Testosterone, DHEA-S, and Cortisol (AM). This profile test currently costs $130.

Office Fee Schedule

New Patient Visits

Initial BHRT Consultation (~1 hour)	$150

BHRT Follow-up Visits

15 Minute Visit (1-15 minutes)	$30
30 Minute Visit (16-30 minutes)	$60
45 Minute Visit (31-45 minutes)	$90

*If the visit extends past your appointment time you will be billed accordingly.

Appointment Cancellation Fee (when less than 24 hour notice is provided) = $25 for follow-up visits; $50 for new patient visits.

Phone Consultations:
Initial BHRT Consultations as well as follow up appointments may be scheduled as a "telehealth or phone consult" to accommodate those who may be out of town or unable to travel to our office. The pharmacy will bill the patient for these consults. Please be sure to allow our staff to answer your questions first before requesting to speak with the clinical pharmacist to avoid needless fees. If our staff is unable to help with your questions, an office visit or phone consult may be scheduled.

We require a credit card to be kept on file for patients requesting mailed prescription orders and for appointment cancellation fees. All fees are due at the time of service.

By signing below, you acknowledge that you have read this document and agree to abide by our office policies.

_____	_____	_____
Patient Name (print)	Patient Signature	Date