

**BUDERER DRUG CO.**

Cor. Hancock & Monroe Sts. Sandusky, Ohio 44870 419-627-2800  
26611 N. Dixie Hwy #119 Perrysburg, Ohio 43551 419-873-2800



**Est. 1878**

# CONSULTANT PHARMACIST AGREEMENT

for

New Patients Starting Natural Bio-identical Hormone  
Replacement Therapy

**Buderer Drug offers an ongoing consultation service for patients who are receiving bio-identical natural hormone replacement therapy. A one time consulting fee of \$65.00 will be charged to you when you start natural bio-identical 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.**

## *Suggested Lab Work for Men*

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 human bio-identical hormone replacement. 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-9 for these labs is 259.9 – Hormone imbalance.

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.

<b>Prescribers Name:</b> _____	<b>Phone:</b> _____
<b>Address:</b> _____	<b>City:</b> _____ <b>State:</b> _____ <b>Zip:</b> _____
<b>For:</b> _____	<b>Date:</b> _____
<b>Address:</b> _____	
<b>R</b>	<b>Laboratory Blood Tests</b>
<b>Estrogens (total)</b>	<b>Dihydrotestosterone</b>
<b>Progesterone</b>	<b>25 hydroxy vitamin D</b>
<b>Testosterone (total)</b>	
<b>Testosterone free</b>	
<b>DHEA-sulfate</b>	
<b>Cortisol</b>	
REFILL _____	
DIAG. or ICD-9 _____	
DEA NO. _____	Signature: _____
<b>BUDERER DRUG CO.</b> EST. 1878	<b>COMPOUNDING PRESCRIPTION</b>
Corner Hancock & Monroe Street - Sandusky, OH 44870 • (419) 627-2800 FAX (419) 626-0494 26611 N. Dixie Highway, Suite 119 - Perrysburg, OH 43551 • (419) 873-2800 FAX (419) 873-0494	

These labs should be drawn in the morning between 7:00-9:00, fasting. If you are currently taking any hormone replacement therapy, the labs should be drawn before taking your medicine.

Your physician may also want to draw thyroid labs. If they do, we suggest the following: TSH, T3 total, T4 total, thyroid binding globulin, thyroglobulin, reverse T3, thyroglobulin antibody, thyroid peroxidase antibody and ferritin.

Consider fasting insulin, glucose, hemoglobin A1c, and C-peptide labs if you suspect Syndrome X or other blood sugar imbalances.

## Natural 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 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 Dietary Supplements: Dihydroepiandrosterone (DHEA), Creatine Phosphate, Anabolic Steroids, Androstenedione, etc.: Y N

Names of products: \_\_\_\_\_

\_\_\_\_\_

Names of ALL **Vitamins, Herbal Products, 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 lab work, enter it here: TSH\_\_\_\_ T<sub>4</sub> \_\_\_\_ T<sub>3</sub> uptake \_\_\_\_ T<sub>7</sub>\_\_\_\_ rT<sub>3</sub> \_\_\_\_ TBG \_\_\_\_ Thyroid Autoantibody \_\_\_\_

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? Please give details: \_\_\_\_\_

\_\_\_\_\_

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? 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 \_\_\_\_\_
- Sexually Transmitted Diseases? Y Details \_\_\_\_\_
- Benign Prostatic Hyperplasia Y Details \_\_\_\_\_  
(BPH)? \_\_\_\_\_
- Abnormal Prostate Enlargement? Y Details \_\_\_\_\_
- Polyps? Y Details \_\_\_\_\_
- Breast Cancer? Y Details \_\_\_\_\_
- Prostate Cancer? Y Details \_\_\_\_\_
- Cancer (any other type) Y Details \_\_\_\_\_

**UROLOGICAL**

When was your last:    General medical exam: \_\_\_\_\_ Prostate exam: \_\_\_\_\_

Have you ever had **Abnormal Prostate Enlargement**? Y N When? \_\_\_\_\_ Treatment: \_\_\_\_\_

Have you been diagnosed with Benign Prostatic Hyperplasia (BPH)? Y N When? \_\_\_\_\_  
Treatment: \_\_\_\_\_

Have you ever had Problems with Urinary Tract Infections (UTI)? Y N When? \_\_\_\_\_  
Treatment: \_\_\_\_\_

Have you ever had Kidney Infections? Y N When? \_\_\_\_\_ Treatment: \_\_\_\_\_

Are you currently having any difficulty urinating? Y N  
If Yes, Describe: \_\_\_\_\_

Any recent unusual penis discharge or itching: Y N Describe: \_\_\_\_\_

Are you currently having any **changes/problems not listed previously**? Y N  
If Yes, Describe: \_\_\_\_\_

Have you had any of the following surgeries:  
Vasectomy? Y N When? \_\_\_\_\_ and at what age? \_\_\_\_\_

Prostate removed (prostatectomy)? Y N When? \_\_\_\_\_ Why? \_\_\_\_\_

Testicles removed (castration)? Y N When? \_\_\_\_\_ Why? \_\_\_\_\_

Any other type of surgery? Y N What type? \_\_\_\_\_ When/Why? \_\_\_\_\_

Were there any problems associated with the surgery or removal of any of these organs? Y N  
If Yes, Describe: \_\_\_\_\_

Have you ever been diagnosed with Breast Cancer? Y N When? \_\_\_\_\_ Treatment? \_\_\_\_\_

Have you ever been diagnosed with Prostate Cancer? Y N When? \_\_\_\_\_ Treatment? \_\_\_\_\_

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 scale of 1 to 10, where would you put it? (10 = most satisfied)

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? \_\_\_\_\_

Have you ever had Erection or Potency Problems? Y N Describe: \_\_\_\_\_

Have you ever had Ejaculation Problems? Y N Describe: \_\_\_\_\_

Have you ever had Loss of Early Morning Erection? Y N

Have you ever had Pain During Intercourse? Y N

If Yes, where and how long? \_\_\_\_\_

When does the pain happen: at the beginning of, during, or after having sex? \_\_\_\_\_

Have you noticed any changes in your Body Hair Patterns? Y N Describe: \_\_\_\_\_

\_\_\_\_\_

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? Y N

If Yes, describe? \_\_\_\_\_

\_\_\_\_\_

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

If Yes, describe? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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)**

	<u>Trend</u>	<u>None</u>	<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>	<u>Your Comments</u>			
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	→
Decrease in Muscle Mass		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)**

	<u>Trend</u>	<u>None</u>	<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>	<u>Your Comments</u>
Dry Skin/Dry Hair -----	----	0	1	2	3	→
Crawling Feeling Under Skin		0	1	2	3	→
Frequent Urinary tract infection/prostate infection	----	0	1	2	3	→
Urinary frequency/incontinence -----	----	0	1	2	3	→
Abnormal Penis Discharge		0	1	2	3	→
Erection/Potency Problems -----	----	0	1	2	3	→
Ejaculation Problems		0	1	2	3	→
Uncomfortable intercourse -----	----	0	1	2	3	→
Loss of Sexual Feeling/Desire		0	1	2	3	→
Loss of Arousability -----	----	0	1	2	3	→
Loss of Early Morning Erection		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	→

**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)**

	<u>Trend</u>	<u>None</u>	<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>	<u>Your Comments</u>
Breast Tenderness		0	1	2	3	→
Swelling of Hands, Ankles, or Breast -----	----	0	1	2	3	→
Food Cravings /Sweets / Salts		0	1	2	3	→
Increased appetite/Weight Gain -----	----	0	1	2	3	→
Loss of Vital Energy (Vitality)		0	1	2	3	→
Acne/Pimples/Skin Flushing -----	----	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 FULL NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

For Office Use:

Barnes Score: \_\_\_\_\_

Oral Score: \_\_\_\_\_

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

### TEMPERATURE LOG

ENTER DATE >				
TAKE YOUR TEMPERATURES AT:	LOCATION TO TAKE AT:	ON FIRST DAY	ON SECOND DAY	ON THIRD DAY
1. Awakening (within 10 minutes)	Under Tongue (5 minutes)			
2. Mid-day	Under Tongue (5 minutes)			
3. Evening	Under Tongue (5 minutes)			
4. Bedtime	Under Tongue (5 minutes)			

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 a mercury **Basal Thermometer**. **If you do not have a basal thermometer**, use any thermometer available but note the type used. Be sure to "sling" the mercury down to 96° F. prior to using thermometer.
2. Sling the mercury down each night before going to bed.
3. In the morning, as soon as you wake up, put the thermometer **UNDER YOUR TONGUE FOR 5 FULL MINUTES**, 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, **UNDER YOUR TONGUE FOR 5 FULL MINUTES**.
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?** \_\_\_\_\_

