Integrative Pharmacists Consulting

Charlene Vernak, Pharmacist
1889 East Lake Road
Skaneateles, New York 13152
315.430.5486 phone
877.812.5417 fax

These items must be completed and on file with the pharmacy prior to your assessment:

- Have your doctor complete the Pharmacist-Physician Collaboration Agreement
- Pharmacy Record Release Authorization Form
- The Consultation and Assessment Form
- Health Insurance Portability and Accountability Act (HIPAA) Form
- Provide copies of any relevant blood and/or saliva tests results if available (ie. estradiol, estriol, estrone, progesterone, testosterone, cortisol, thyroid, etc.)

Pharmacist-Physician Collaboration Agreement

Your patient, _______________________________, has requested an *Integrative Pharmacy Consult* by our pharmacist Charlene Vernak, RPh doing business as Integrative Pharmacy Consultants.

Our goal is to work with you to help your patient optimize their care by conducting a comprehensive pharmacy evaluation for an individual patient by a pharmacist who is dedicating an appropriate amount of time to evaluate drug interactions, side effects and disease state interactions.

We will review your patient's entire medication list which would include the current drug therapies, vitamins, herbs and supplements.

We use Clinical Pharmacology Software to assist us in our evaluation and to help us to make recommendations regarding traditional medications.

We are available to you and happy to fax or mail this information to your office upon request.

Our assessment includes but is not limited to a review of symptoms, disease states, medical history, family history and submitted labs. In addition we will review current medications, vitamins, herbs and supplements to help to evaluate compliance, patient satisfaction and to secure better results for your patients.

Some patients may not have responded to, did not tolerate or would like to improve upon their current health care regimens with vitamins, herbs and supplements. Our pharmacist, Charlene is trained in compounding, nutrition and metabolic medicine and is prepared to offer reasonable suggestions to augment your current care when non traditional options may be helpful.

We will fax or mail you recommendations and suggestions upon your patients completion of our evaluation and will be available to you to discuss further ideas.

I, ______________________________________ (Physician Name), authorize Charlene Vernak, RPh doing business as Integrative Pharmacy Consultants to assess and evaluate ______________________________________ (Patient Name), and make recommendations to me regarding my patient's treatment.

Signature: ______________________________________

Date: ________________________

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Health Insurance Portability and Accountability Act (HIPAA) Form

I Have read and agree to the Integrative Pharmacist Consulting Health Insurance Portability and Accountability Act (HIPAA) Form.

Date:

Patient Name:

Parent Name:

I consent to the release of my health information to:

____

Signature of Patient:

____

PHARMACY RECORD RELEASE AUTHORIZATION

I, the undersigned patient, authorize my pharmacist to release my personal medication and/or other medical information to the following persons or organizations upon request or as deemed necessary:

	NAME	ADDRESS	TELEPHONE
1.			
2.			
3.			

I understand that employees of Integrative Pharmacy Consultants will protect my privacy and this information will be released to other healthcare professionals only when it is necessary in order to provide healthcare services to me. This authority shall continue until revoked by me in writing.

Patient Name: ____________________

Address: ____________________

City, State, Zip: ____________________

Phone: ____________________

Signature: ____________________

Date: ____________________

Female Consultation and Assessment Form

Today's Date___________________________________

Name _______________________________________ Date of Birth ___________________________

Address ____

Home Phone ______________________________Cell Phone _________________________________

Email ____

Height _______________ Weight ________________ Gender__________________________________

Gender __________________________________ Occupation ________________________________

Referring Source____

Primary Care Provider____

What are your greatest needs or problems? (List the most important; then list other issues in order of importance):

____

____

____

____

____

____

____

____

____

____

Medical Conditions/Diseases: Please check all that apply to **you**.

___ Heart disease (example: Congestive Heart Failure)

___ Blood Clotting Problems
___ High cholesterol or lipids (examples: Hyperlipidemia)
___ Diabetes
___ High blood pressure (example: Hypertension)
___ Arthritis or joint problems
___ Cancer
___ Depression
___ Ulcers (stomach, esophagus)
___ Epilepsy
___ Thyroid disease
___ Headaches/migraines
___ Hormonal Related Issues
___ Eye Disease (glaucoma, etc.)
___ Lung condition (example: asthma, emphysema, COPD)

Other medical conditions: Please list: ____

____

____

____

Drug Allergies: ____

Allergies to food, pollens, environment, etc: ____

Have you recently developed allergies that you have not had before___________________________

Do you have any sensitivities to chemicals____

Have you ever taken or are you currently on any hormone replacement therapy? (If so list the medications, including strength & how you take them): ____

____

____

____

Names of ALL prescription and OTC medications you are currently taking (include strength & how you take them):

____

____

____

____

Indicate any vitamins, herbal products and/or supplements that you have taken and possible adverse reactions to them:

____

____

____

Have you ever had surgery? Please give dates and Describe____

Have you ever had a bone density scan? YES NO

If so when? ______________________ Results? ____

Lifestyle: If yes, 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 use recreational drugs? Yes No ____

How much water do you drink in one day (24 hr)?____

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

____

Integrative Pharmacist Consulting - Charlene Vernak, RPh

Do you have a FAMILY history of any of the following?

Uterine Cancer	____________	Family member(s) ______________________
Ovarian Cancer	____________	Family member(s) ______________________
Fibrocystic breast	____________	Famil member(s) ______________________
Breast Cancer	____________	Family member(s) ______________________
Heart Disease	____________	Family member(s) ______________________
Stroke	____________	Family member(s)______________________
Hypertension	____________	Family member(s)______________________
Diabetes	____________	Family member(s)______________________
High Cholesterol	____________	Family member(s)______________________
Irritable Bowel	____________	Family member(s)______________________
Osteoporosis	____________	Family member(s) ______________________
Alzheimers	____________	Family member(s)______________________
Anxiety disorder	____________	Family member(s)______________________
Depression	____________	Family member(s)______________________

Other notable family history: ____

____

____

____

Describe your bowel habits:

____

____

____

Are you regular:____

Are you often constipated____

Do you regularly have diarrhea?____

How often do you have a bowel movement?

____

Do you suffer from bloating?____

Do you suffer from stomach cramps?____

Do you suffer from gas?____

Do you have inflammation in the abdominal area?____________________________________
Do you suffer from heartburn?____

Other abdominal issues:

____

When was your last general medical exam: ______________________________________

When was your last pelvic exam: ____

Menstrual Cycle and Gynecologic Information:

Have you ever had an abnormal Pap? YES NO

If so 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? YES NO

If yes, how many days from the start of one period to the start of the next? ______________________

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? YES NO

If so where, when, how long? ____

Any current changes in your normal cycle? ____

Any bleeding between periods (IMB)? YES NO

When and describe: ____

What were your periods like as a teenager? ____

____

If you have ever had premenstrual symptoms (PMS), please describe: ______________________________

____

How long have you had PMS symptoms? ____

Starting and ending when? ____

If your periods have ever been difficult, irregular, or abnormal in any way, please describe: ______________

____

____

If you are currently having any pelvic pain, pressure, or fullness, describe: ___________________________

____

Describe any recent unusual vaginal discharge, numbness or itching:_______________________________

____

Treatment for any of above: ____

Have you ever had any of the following surgeries?

Tubes tied (tubal ligation)? YES NO
When? ______________________________ At what age? ______________________________

Uterus removed (hysterectomy)? YES NO
When? ________________________ Why? ____

Ovaries removed (oophorectomy)? YES NO

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? YES NO

If yes, at what age? ____

If at age 40 years or earlier, was Premature Ovarian Failure diagnosed? YES NO

Have you ever been pregnant? YES NO

Are you trying to get pregnant? YES NO

What was your age at your first pregnancy? ______________________________________

How many times have you been pregnant? ____

How many pregnancies resulted in the birth of living children? ______________________

Were there any problems? ____

Any interrupted pregnancies (miscarriages or abortions)? __________________________

Current birth control method: ____

How long: ___________________________Any problems? __________________________

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

Oral Contraceptives (Birth Control Pills): YES NO

Total months/years used: ____

Describe any side effects to Birth Control Pills: _______________________

Intra-Uterine Device (IUD): YES NO

Problems: ____

When was your last mammogram? ____

Results: ____

Do you exam your breasts monthly? ____

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? ___________

____

Have you ever been diagnosed with a sexually transmitted disease or do you have a history of vaginal infections. If so, please describe:____

____

____

Did you mother take DES during her pregnancy with you?____

Have you ever been diagnosed with an autoimmune condition? If so, please describe

____

Has anyone in your family ever been diagnosed with an autoimmune condition?

____

Have you ever had a serious infection (example...EBV or mononucleosis, Lymes disease, Hepatitis, etc). If so, please list.

____

____

Have you ever been diagnosed with anemia, vitamin d deficiency or or any other type of nutritional deficiencies?

____

Do you have a history of any skin issues such as eczema, psoriasis or long standing acne?____

Describe the quality of your skin

____

Do cuts heal easily____

Do you scar easily____

Do you bruise easily____

Any history of skin issues or conditions in the past. Please describe.

____

____

____

Describe the quality of your nails:

____

____

Any recent changes____

Ridges-vertical____

Ridges-Horizontal____

Discoloration____

Indentations____

Any Peeling____

Strong, brittle, tear easily or in between____

Any Thickening of the nail beds____

Describe the quality of your hair.

____

Any changes in texture____

Is it drier than
normal____

Is it falling out? If so where

____

____

How Stressed are you? Please describe emotional, physical, family or work related stres that might be interfering with your overall health

____

____

What do you do to manage stress____

____

Are you happy with your sex drive____

____

Are you able to achieve orgasm? Has your ability to achieve orgasm changed?____

____

If you are sexually active, is intercourse painful?____

____

Does vaginal dryness or pain interfere with sexual pleasure or orgasm?____

____

Do you exercise, if so please describe

____

____

Describe your sleep-Any difficulty falling asleep____

____

Difficulty staying asleep____

what wakes you up at night____

do you feel refreshed in the morning____

Max average hours of sleep in a row____

Max average hours of sleep per night

____

Do you suffer from fatigue during the day? If so, is it worse at certain times of the day?

____

____

Do you have difficulty staying awake during the day? Do you spontaneously fall asleep without trying?____

Have you gained an unusual amount of weight in a short amount of time? If so, please describe:____

____

____

If so, where has the fat accumulated?

____

____

Do you have difficulty building muscle? If so, Please describe

____

____

Do you break out into sweats? If so, how often

____

Have you ever been told that your blood sugar is high, but not been diagnosed with diabetes?____

____

Do you have hot flashes? If so, please describe and list how many per day?____

____

Do you have body pain? If so, please describe

____

Location of pain : is it all over or in specific areas____

Is it bone pain, tissue pain, please describe

____

Does your pain limit your daily activities?____

Does your pain affect your sleep?____

Do you have high blood pressure or does your blood pressure elevate when you are upset?____

____

If your doctor has recently ordered lab tests or diagnostic procedures for you, please give details, including whether the test or procedure was performed, and the results:

____

____

Symptom Check List

Please check all symptoms and the degree of the symptoms intensity you have experienced over the past 3 months. If you wish to add comments or details, please do so on the last page.

	ABSENT	MILD	MODERATE	SEVERE
Fibrocystic Breast	________	________	________	________
Weight Gain	________	________	________	________
Heavy menses	________	________	________	________
Irregular Menses	________	________	________	________
Hot Flashes	________	________	________	________
Dry Skin	________	________	________	________
Dry Hair	________	________	________	________
Anxiety	________	________	________	________
Depression	________	________	________	________
Nervousness	________	________	________	________
Night Sweats	________	________	________	________
Vaginal Dryness	________	________	________	________
Vaginal Discharge	________	________	________	________
Vaginal Itchiness	________	________	________	________
Headaches	________	________	________	________
Irritability	________	________	________	________
Mood Swings	________	________	________	________
Breast Tenderness	________	________	________	________

Sleep Disturbances/Insomnia				
Cramps				
Fluid Retention				
Breakthrough Bleeding				
Fatigue				
Loss of Memory				
Bladder Retention				
Urinary Leakage				
Urinary Retention				
Arthritis				
Harder to Reach Climax				
Decreased Sex Drive				
Decreased Stamina				
Painful Intercourse				
Increased sex drive				
Excessive sweating				
Excessive Thirst				
Hair Loss (scalp)				
Loss of Pubic Hair				
New Hair Growth (face)				
New Hair Growth (body)				
Heart Palpitations				
Sugar Cravings				
Acne				

Constipation	_____	_____	_____	_____
Diarrhea	_____	_____	_____	_____
Heartburn	_____	_____	_____	_____
Bloating/Gas	_____	_____	_____	_____
Feeling Cold	_____	_____	_____	_____
Feeling hot	_____	_____	_____	_____
Breast Discharge	_____	_____	_____	_____

Other symptoms not listed or in depth description of symptoms listed above:

____

____

____

____

____

____

Please write down any questions you have that we didn't address on this form

____

____

____

Please Note:

The recommendations you will receive from Charlene Vernak, Integrative Pharmacist Consulting are made based on mutual engagement from the patient and from your other medical providers. In order to achieve the best results we need feedback from both you and your provider as to the status of our recommendations. Follow up labs to evaluate improvement would be a tremendous asset to our ongoing relationship to assess improvement in your health. We are striving for lab optimal. If you are looking for recommendations on compounded bioidentical hormones we would request saliva testing and basic labs as a gold standard to measure your progress. We would request to discuss these labs with your provider at the onset of treatment, once established and then every six months to one year while on custom hormone therapy based on the health of the patient. Please forward and discuss this information with your medical provider.