Physicians for BHRT

If you do not have a physician, we can provide you with a list of practitioners we work with to prescribe bio-identical hormone replacement therapy. Tell them Joseph L. Rossetti, R.Ph. at Boulevard Pharmaceutical Compounding Center recommended them for BHRT therapy.

Professional Nutritional Supplements

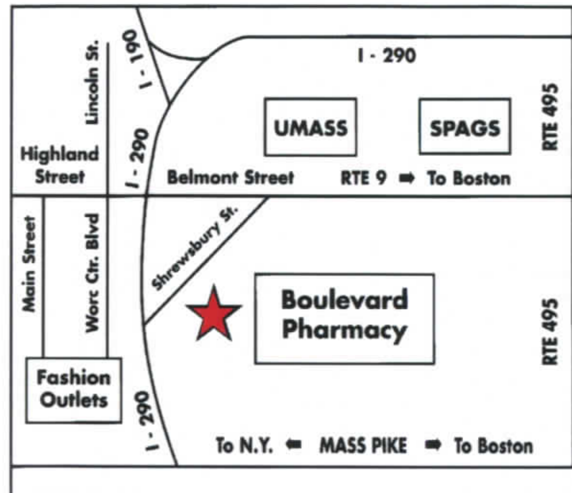
At Boulevard Pharmaceutical Compounding Center, we carry a variety of professional-grade nutritional supplements. We encourage you to discuss your needs with one of our friendly staff members. We carry

- Metagenics
- Douglas Labs
- Pure Encapsulations
- Orthomolecular
- Designs for Health
- Natural Factors
- New Chapter
- Boiron Homeopathics
- Innate

BOULEVARD

Pharmaceutical Compounding Center

Joseph L. Rossetti, B.S., R.Ph.



149 Shrewsbury Street
Worcester, MA 01604
Tel: 508-754-1791
Toll Free: 855-345-4296
Fax: 508-795-0813

HOURS

Monday through Friday
9:00am - 6:00pm

Email: info@blvdcompounding.com
Website: www.boulevardcompounding.com

Personal Consultation for Bio-Identical Hormone Replacement Therapy

BOULEVARD

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Joseph L. Rossetti, B.S., R.Ph.

The Benefits of a Personal Consultation!

No one knows your body better than you.

At Boulevard Pharmaceutical Compounding Center (BPCC), we believe your questions and your symptoms are keys to restoring your health! In order to help men and women and their doctors choose the correct hormone therapy, proper dose and dosage form, BPCC offers private patient consultations with Joseph L. Rossetti, R.Ph.

How to Schedule your Personal Consultation

BPCC wants to partner with your physician to ensure your success with your custom compounded prescriptions. To that end, new patients will schedule a personal one-on-one consultation with Joseph L. Rossetti, R.Ph. by calling and speaking with one of our Certified Pharmacy Technicians 508-754-1791 or toll free 855-345-4296.

Requirements

A completed personal health evaluation form must be received no less than 1 day prior to the personal one-on-one consultation. You may pick up a form at the pharmacy or we can fax upon request.

Your physician will perform the required HRT tests and in most cases fax the results to us directly. However, test results must be received no less than 1 day prior to your scheduled consultation.

You can fax your personal health evaluation form to the pharmacy at 508-795-0813.

Your Consultation Appointment

At your consultation appointment, you will review your evaluation form with the pharmacist, highlighting your symptoms, medical and family history, test results and current medications. Then Joseph L. Rossetti, R.Ph. will recommend a course of therapy for you and will help you decide the best delivery system for your hormone replacement. He will then contact your physician with his findings.

Your consultation will take approximately 45-60 minutes. You'll develop a better understanding of your body, your symptoms and how you can become an active participant in restoring your health. You'll also learn adjunctive therapies, nutritional and physical changes you can make to enhance your therapy. Best of all, you'll have the undivided attention of a highly trained professional who will lay out a unique health strategy designed specifically for you.

Consultation Fee

The consultation fee is $100 and is payable at the time of the appointment. Follow-up calls to the pharmacist are at no charge.

BPCC does not bill insurance plans for its services or products. However, the staff is always happy to assist patients in completing the necessary insurance forms to request reimbursement. If you need help with your insurance forms, don't hesitate to bring them in with you when you pick up your prescription.

Starting your Bio-Identical Hormones

After a prescription is signed by your physician (your physician may fax it to us), your preparation will be custom compounded just for you. Your prescription will be ready in approximately 3 days.

Keep in Touch!

Remember - your body and your life are constantly changing! Your prescriptions may need to be adjusted occasionally, too!

Close monitoring is important to ensure proper dosage adjustments and avoid unnecessary side effects. We urge you to keep in touch with your physician regarding your progress, and to contact your physician if you notice any symptoms or changes that may indicate an adjustment in your prescription may be necessary.

Because We Value Your Business

After your first consultation, you will receive a $25 gift certificate towards nutritional products and 20% off your nutritional supplement purchases for 90 days excluding already marked down supplements.

Remember
No One Knows Your Body Better Than You!

FINDING THE BALANCE

SYMPTOMS LIST CHART

PATIENT____

DATE________________________

LACK OF PROGESTERONE:

__HEADACHE
__YEAST INFECTIONS
__ANXIETY
__SWOLLEN BREASTS
__MOODINESS
__DEPRESSION
__IRRITABILITY
__INSOMNIA
__CRAMPS
__PAINFUL BREASTS
__WEIGHT GAIN
__BLOATING
__EARLY MENESTRATION
__PAINFUL JOINTS

LACK OF ESTROGEN:

__HOT FLASHES
__NIGHT SWEATS
__SLEEP DISORDERS
__VAGINAL DISORDERS
__DRY SKIN
__VAGINAL SHRINKAGE
__PAINFUL INTERCOURSE
__LACK OF MENESTRATION

LACK OF TESTOSTERONE:

__FATIGUE, PROLONGED
__MEMORY PROBLEMS
__DECREASED LIBIDO
__MUSCLE WEAKNESS
__BONE LOSS
__MENTAL FUZZINESS
__BLUNTED MOTIVATION
__DIMINISHED FEELING OF WELL BEING
__VAGINAL DRYNESS
__GENERAL ACHES/PAINS

Patient Signature: ____________________________________ Date: _______

CONFIDENTIAL HORMONE EVALUATION

MEDICAL HISTORY

Today's Date:_____________

Name: ____ Birth date: _______ Age: ___

Address: ____

City: ________________________________ State: _______ Zip: ______________

Phone:________________________________ Email: _________________________

Gender: Male [ ] Female [ ] Height: _________ Weight: _______

			How often and how much?
Do you use tobacco?	Yes [ ]	No [ ]	____________________________________
Do you consume alcohol?	Yes [ ]	No [ ]	____________________________________
Do you consume caffeine?	Yes [ ]	No [ ]	____________________________________

Doctor's Name: Address: Phone:

____

____

____

____

____

Allergies: Please check all that apply

__ Penicillin	__ Morphine	__ Dye Allergies	__ Pet Allergies
__ Codeine	__ Aspirin	__ Nitrate Allergy	__ Seasonal (Pollen)
__ Sulfa Drug	__ Food Allergies	__ No Known Allergies	__ Other: _________

Please describe the allergic reaction you experienced and when it occurred?

____

____

____

Patient Signature: ____________________________________ Date: _______

Over-the-counter (OTC) issues:
Please check all products that you use occasionally or regularly. Check all that apply.

__ Pain Reliever
__ Aspirin
__ Acetaminphen (example: Tylenol)
__ Ibuprofen (example: Motrin IB)
__ Naproxen (example: Aleve)
__ Ketoprofen (example: Orudis KT)
__ Cough suppressant (example: Robitussin DM)
__ Antihistamine product (example: Chlor-Trimeton)
__Decongestant product (example: Sudafed)
__Combination product (cough/cold reliever)
__Sleep aids: Excedrin PC , Unisom, Sominex, Nytal)
__Antidiarrheals (examples: Imodium, Pepto Bismo, Kaopectate)
__Laxatives/stool softners (examples: Doxidan, Correctol, etc)
__Diet aids/weight loss products (example: Dextril)
__Antacids (examples: Maalox, Mylanta)
__Acid blockers (examples: Tagament HE, Pepcid C, Zantac 75
__Other (Please List): ____

Nutritional/ Natural Supplements: Please Identify and list the products you are using:

[ ] Vitamins (examples: multiple or single vitamins such as B complex, E, C, beta carotene)
____

[ ] Minerals (examples: calcium, magnesium, chromium, colloidal minerals, various single minerals)
____

[ ] Herbs (examples: Ginseng, Ginkgo Biloba, Echinacea, other herbal medicinal teas, tinctures, remedies, etc.)

[ ] Enzymes (examples: digestiveformulas, papaya, bromelain, coEnzyme Q10, etc)
____

[ ] Nutrition/protein supplements (examples: shark cartilage, protein powers, amino acids, fish oils, etc)
____

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

__Heart disease (example: Congestive Heart Failure)
__High Cholesterol or lipids (examples: Hyperlipidemia)
__Cancer
__Ulcers (stomach, esophagus)
__Thyroid disease
__Hormonal related Issues
__Lung condition (example: asthma, emphysema, COPD)
__High blood pressure (example: Hypertension)
__Other (Please specify):__________________________
__Blood Clotting Problems
__Diabetes
__Arthritis or joint problems
__Depression
__Epilepsy
__Headaches/migraines
__Eye Disease (glaucoma, etc)

____
____
____

Patient Signature: ______________________________________ Date: _______

Current Prescription Medications:

Medication Name:	Strength:	Date Started:	How Often Per Day:
____________________	_______	__________	______________
____________________	_______	__________	______________
____________________	_______	__________	______________
____________________	_______	__________	______________

List Hormones previously taken:	Date started:	Date Stopped:	Reason:
__________________________	__________	___________	______________
__________________________	__________	___________	______________
__________________________	__________	___________	______________

Bone Size: Small: _________ Medium: ___ Large: ______

Body Type: [ ] Androgenic [ ] Estrogenic

Have you ever used oral contraceptives? [ ] No [ ] Yes
Any Problems? [ ] No [ ] Yes
If **YES**, describe any problem(s)

____
____
____
____

How many pregnancies have you had? ___ How many children ___________________

Any interrupted pregnancies? [ ] No [ ] Yes
Have you had a hysterectomy? [ ] No [ ] Yes (Date of Surgery) _______________
Ovaries removed? [ ] No [ ] Yes
Have you had a tubal ligation? [ ] No [ ] Yes (Date of Surgery)_______________

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

Uterine Cancer ______________________ Family member(s)_____________________
Ovarian Cancer______________________ Family member(s) ____________________
Fibercystic breast____________________ Family member(s) ____________________
Breast Cancer_______________________ Family member(s) ____________________
Heart Disease_______________________ Family member(s) ____________________
Osteoporosis________________________ Family member(s) ____________________

Patient Signature: ___________________________________ Date: _______

Have you had any of the following tests performed? Check those that apply and note date of last test.

Mammography: [ ] No [ ] Yes Date:________________________
PAP Smear: [ ] No [ ] Yes Date:________________________

Since you first began having periods, have you ever had what YOU consider to be abnormal cycles: [ ] No [ ] Yes Date:________________________

If YES, Please explain (Such as age when this occurred, symptoms....):

____
____
____
____

When was your last period: ______________________
How many days did it last: ______________________

Do you have, or did you ever have Premenstrual Syndrome (PMS): [ ] No [ ] Yes
If YES, explain symptoms:

____
____
____
____

How did you arrive at the decision to consider Bio-Identical Hormone Replacement Therapy?

Doctor [ ] Self [ ] Friend/Family Member [ ] Other [ ]

What are your goals with taking BHRT?

____
____
____
____
____

Please write down any questions you have about Bio-Identical Hormone Replacement Therapy.

Patient Signature: ____________________________________ Date: _______

BOULEVARD PHARMACEUTICAL
COMPOUNDING CENTER
149 SHREWSBURY ST, WORCESTER, MA 01604
(508) 754-1791 (855) 345-4296 FAX (508) 795-0813
JOSEPH L ROSSETTI, RPH, MGR., OWNER
Hours of Operation: M-F 9am-6pm

TEST REQUIRED FOR BHRT THERAPY

(BIO-IDENTICAL HORMONE REPLACEMENT THERAPY)

NECESSARY TESTS:

1. Estradiol
2. Progesterone
3. Testosterone (Free)
4. Dhea
5. Cortisol (AM)
6. TSH (Thyroid Stimulating Hormone)-may be available from past labs

NOTE: Serum tests and saliva tests may differ with topical preparations due to the fact that topicals miss the first liver bypass.

ADDITIONAL TEST THAT ARE HELPFUL FOR BOTH BHRT AND WEIGHT CONTROL:

1. T-3
2. T-4
3. Skin Test For Iodine **(in-pharmacy test)**
4. Zinc Test **(in-pharmacy test)**
5. Temperature- At home with a ***digital*** thermometer keep a record of your temperature in AM before getting out of bed, mid-day.
   Note: If temperature is consistently lower than normal inform your physician.

Patient Signature: ____________________________________ Date: _______