Doug's Compounding Pharmacy
Healthcare as Individual as You

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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 in the questions below will allow the pharmacist to maintain your medical history and will help in advising about current medical therapies. All information provided will be kept confidential.

GENERAL INFORMATION

Date: _____

Name: _____ Age: _____ Birth Date: _____

Address: _____

Home Phone Number: _____ Work Phone Number: _____

Cellular Phone:_____ E-mail:_____

Occupation: _____ Full-Time ____ Part-Time ____ Retired ____ Unemployed ____ Other ____

Living Situation: Spouse ____ Alone ____ Partner ___ Friend(s) ____ Parents ____ Children ____ Other _____

Status: Married ____ Single____ Divorced ____ Widowed ____

Pets: _____

How did you hear about Natural Hormone Replacement Therapy: Ad ____ Another Patient____

Courses/Seminars ____ Physician/Healthcare practitioner ___ Books/Articles ____ Other ____

Do you understand what Natural Hormone Replacement is:_____

What are your goals for Natural Hormone Replacement: _____

_____

MEDICAL STATUS

General Health: Excellent ____ Good ____ Fair ____ Poor ____ Height: _____ Weight: _____

Current diagnosis or medical conditions: _____

_____

Drug Allergies: _____

_____

Allergies to food, pollens, etc.: _____

_____

Current Medications: _____

_____

Current Vitamins or OTC products: _____

_____

Have you ever had your cholesterol level checked: _____ Date: _____ Results: _____

Have you ever had a mammogram: _____ Date: _____ Results: _____

Have you ever had a bone density scan: _____ Date: _____ Results: _____

Current/Recent Health Care Providers: _____

_____

PAST MEDICAL CONDITIONS

Childhood diseases: _____

Heart Trouble _____ High Blood Pressure _____ Stroke _____ Varicose Veins _____

Clotting Defects _____ Diabetes _____ Kidney Trouble _____ Epilepsy _____ Fractures _____

Arthritis _____ Colitis _____ Gallbladder Trouble _____ Asthma _____ Chronic Fatigue _____

Fibromyalgia _____ Eating Disorder _____ Cancer _____

HABITS

Dietary Restrictions: _____

Meal Choices: Breakfast: _____
Lunch: _____
Dinner: _____

Do you get routine physical exercise: _____ What type: _____

Do you use tobacco products: _____ How much: _____ Previously: _____ How Long: _____

Do you use alcohol products: _____ How much: _____ Previously: _____ How Long: _____

Do you use caffeine products: _____ How much: _____

FAMILY HISTORY

Please list family members and their age which are **still living** that may have important diseases such as;

High Blood Pressure, Heart Disease, Cancer, Diabetes, Osteoporosis, etc.:

Name:_____Disease:_____Age:_____

Name:_____Disease:_____Age:_____

Name:_____Disease:_____Age:_____

Please list family members who **died** of important diseases (see above question) and their age at the time of death:

Name:_____Disease:_____Age at death:_____

Name:_____Disease:_____Age at death:_____

Name:_____Disease:_____Age at death:_____

GYNECOLOGICAL HISTORY

Age of first period: _____ Date of last period: _____

Date of last pelvic exam: _____ and Pap smear: _____ Results? _____

Have you had an endometrial ablation? _____ Date: _____ Results? _____

Have you ever had an abnormal pap? _____ Treatment: _____

Are you sexually active? _____ Are you trying to get pregnant? _____

Current birth control method: _____ How long: _____

Problem with it: _____ How long: _____

Past birth control and any related problems: _____

Do you have an IUD? _____

How many days from start of one period to the start of the next: _____

Number of days of flow: _____ Amount of bleeding: _____

Amount of cramps: _____

Premenstrual symptoms: _____

Starting and ending when: _____

Any current changes in your normal cycle: _____

Any bleeding between periods: _____ When: _____

Any pelvic pain, pressure or fullness? _____ Describe: _____

Any unusual vaginal discharge or itching? _____ Describe: _____

Treatment: _____

Age of first pregnancy: _____

How many full term pregnancies? _____ Problems: _____

_____

_____

Any interrupted pregnancies? (miscarriages or abortions) _____

_____

Have you had a tubal ligation? _____ When? _____

Have you had any part or whole ovary removed? _____ When? _____

Have you had a hysterectomy? _____ When? _____

Do your ovaries remain? _____

CONSULTATION NOTES

(for pharmacist use) _____

_____

_____

_____