



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.

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GENERAL INFORMATION

Date: _____

Name: _____ Age: _____ Birth date: _____

Address: _____

Home phone: _____ Work phone: _____

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? _____

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MEDICAL STATUS

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

Current diagnosis or medical conditions: _____

Drug allergies: _____

Allergies to food, pollen, etc: _____

Current Medications: _____

Current vitamins or OTC products: _____

Current Herbs/etc: _____

Have you ever had your cholesterol level checked? Yes No Date: _____ Results: _____

Have you ever had a mammogram? Yes No Date: _____ Results: _____

Have you ever had a bone density scan? Yes No Date: _____ Results: _____

Current/Recent Health Care Providers: _____

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PAST MEDICAL CONDITIONS

Childhood diseases: _____

Heart Trouble High Blood Pressure Stroke Varicose Veins Clotting Defects

Diabetes Kidney Trouble Epilepsy Fractures Arthritis Colitis Cancer

Gallbladder Trouble Asthma Chronic Fatigue Fibromyalgia Eating Disorder

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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? _____

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FAMILY HISTORY

Please list family member and their ages who are still living that may have important disease such as: High Blood Pressure, Heart Disease, Cancer, Diabetes, Osteoporosis, etc: _____

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

GYNECOLOGICAL HISTORY

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

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

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 at 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? _____

SYMPTOMS I

Rate your current status for each symptom by checking the appropriate modifier. Please feel free to use additional space to describe any symptom. This section may be repeated upon subsequent visits.

	Absent	Mild	Moderate	Severe
1. Headaches	_____	_____	_____	_____

2. Low Libido	_____	_____	_____	_____

3. Anxiety	_____	_____	_____	_____

4. Swollen Breast	_____	_____	_____	_____

5. Moodiness	_____	_____	_____	_____

6. Fuzzy Thinking	_____	_____	_____	_____

7. Depression	_____	_____	_____	_____

8. Food Cravings	_____	_____	_____	_____

9. Irritability	_____	_____	_____	_____

10. Insomnia	_____	_____	_____	_____

11. Cramps	_____	_____	_____	_____

12. Emotional Swings	_____	_____	_____	_____

13. Painful Breast	_____	_____	_____	_____

14. Weight Gain	_____	_____	_____	_____

15. Bloating	_____	_____	_____	_____

16. Inability to Concentrate	_____	_____	_____	_____

SYMPTOMS II

	Absent	Mild	Moderate	Severe
1. Hot Flashes	_____	_____	_____	_____
2. Shortness of breath	_____	_____	_____	_____
3. Night Sweats	_____	_____	_____	_____
4. Sleep disorders, Insomnia	_____	_____	_____	_____
5. Vaginal Dryness	_____	_____	_____	_____
6. Dry Hair/Skin	_____	_____	_____	_____
7. Hair Loss	_____	_____	_____	_____
8. Anxiety	_____	_____	_____	_____
9. Mood Swings	_____	_____	_____	_____
10. Headaches	_____	_____	_____	_____
11. Depression	_____	_____	_____	_____
12. Short Term Memory Loss	_____	_____	_____	_____
13. Frequent Urinary Tract Infections	_____	_____	_____	_____
14. Heart Palpitations	_____	_____	_____	_____
15. Frequent Yeast Infections	_____	_____	_____	_____
16. Vaginal Shrinking	_____	_____	_____	_____
17. Loss of Pubic Hair	_____	_____	_____	_____

18. Painful Intercourse _____

19. Inability to Reach Orgasm _____



SYMPTOMS III

	Absent	Mild	Moderate	Severe
1. Water Retention, Enema	_____	_____	_____	_____

2. Fatigue, Lack of Energy	_____	_____	_____	_____
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3. Breast Swelling	_____	_____	_____	_____
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4. Fibrocystic Breast	_____	_____	_____	_____
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5. Premenstrual Mood Swings	_____	_____	_____	_____
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6. Loss of Sex Drive	_____	_____	_____	_____
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7. Heavy or Irregular Menses	_____	_____	_____	_____
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8. Uterine Fibroids	_____	_____	_____	_____
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9. Cravings for Sweets	_____	_____	_____	_____
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10. Weight Gain (Hips & Thighs)	_____	_____	_____	_____
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11. Symptoms of Low Thyroid	_____	_____	_____	_____
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