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www.ProCompounding.com

Hormone Replacement Therapy Consultation Form

Name: _____ Date: _____

Date of Birth: _____ Height _____ Weight _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Care Physician: _____ OBGYN: _____

Is either physician aware of your interest in HRT? _____

Email: _____

Work Phone: _____ Occupation: _____

How did you hear about ProCompounding Pharmacy's Hormone Program? _____

What is your greatest need or problem? (List the most important, then list other issues in order of importance) _____

Your Current medical conditions or diagnoses: _____

Drug Allergies: _____

Allergies to food, pollen, environment, etc: _____

Names of ALL prescription medications taken in the last 6 months. Include strength and how you take them: _____

Indicate any herbal products you have taken: _____

Names of ALL Vitamins, Supplements, Non-Prescription medicines or other OTC products that you are currently using:

If you re currently taking medication for a thyroid condition, which one and dose? _____

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

If yes, when? _____ Results? _____

Do you use tobacco products? Yes _____ No _____

If yes, What? _____ How Much? _____ How Long? _____

Do you use alcohol products? Yes _____ No _____

What? _____ How Much? _____ How Long? _____

Do you use caffeine products? Yes _____ No _____

What? _____ How Much? _____

How much water do you drink in one day (24 hour)? _____ oz. _____ glasses.

Do you have any dietary restrictions (such as salt, carbohydrates, milk products, red meat, etc) _____

When was your last: General medical exam _____ Pelvic exam _____

Have you ever had an abnormal pap? Yes _____ No _____ When? _____

At what age was your first period? _____

When was your most recent or last period? _____

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? _____ days

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 _____

Any current changes in your normal cycle? _____

Any bleeding between periods? _____

When? _____ Describe: _____

What were your periods like as a teenager? _____

If you 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 vaginal discharge or itching: _____

Treatment of any of the 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? _____ At what age? _____

Ovaries removed (oophorectomy)? Yes ___ No ___ When? _____ At what age? _____

Where 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 the age of your first pregnancy? _____ How many times have you been pregnant? _____

How many resulted in the birth of living children? _____

Were there any problems? _____

Any interrupted pregnancies (miscarriage or abortions)? Yes ___ No ___

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: _____

Any side effects to Birth Control Pills: _____

Intra-Uterine Device (IUD) Yes ___ No ___ Problems _____

When was your last mammogram? _____ Results _____

Do you examine your breast monthly? Yes ___ No ___

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 condition? _____

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: _____

CHECK A BOX FOR EACH SYMPTOM which best describes how you have been feeling for the past months. *This only needs to be filled out if you are not interested in saliva testing. This questionnaire will help us to recommend a customized hormone plan to submit to your physician.*

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)

Hot Flashes	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Night Sweats	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Light-headed feeling / dizziness	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Headaches	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Sleep disorders / Sleeplessness	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Unusual tiredness / Fatigue	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Irritability	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Depression	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Anxiety / Tension / Nervousness	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Mood Swings / Mood Changes	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Confusion / Difficulty Concentrating	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Forgetfulness / Short-term memory loss	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Angry outbursts / Arguments / Violent tendencies	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Crying easily	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
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Backache	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Joint pains	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Muscle pains	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Muscle cramps / spasms	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Problems with wound healing times	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Acne / pimples / Skin flushing	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Dry skin / Dry Hair	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Crawling feeling under skin	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
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Frequent Urinary Tract Infections (UTI)	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Urinary frequency	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Vaginal dryness	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Abnormal bleeding	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Pelvic pain, pressure, fullness, or bloating	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Uncomfortable intercourse	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Loss of sexual feeling / desire	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Loss of arousability and capacity for orgasm	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Loss of sexual sensitivity	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Loss of vitality	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Nipple sensitivity	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Discharge or leaking from nipples	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Breast tenderness	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Loss of pubic hair	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Swelling of hands, ankles, or breasts	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Heart palpitations	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
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Shortness of breath	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Food/sweets/salt cravings	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Increased appetite / weight gain	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3