PRO COMPOUNDING PHARMACY Rx

Topical Pain • Ear, Nose & Throat • Podiatry • Veterinary • Wound Care
Men's Health • Women's Health • Sexual Health • Hormone Replacement

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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 BHRT? _____

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 preformed 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)

Symptom	0	1	2	3
Hot Flashes				
Night Sweats				
Light-headed feeling / dizziness				
Headaches				
Sleep disorders / Sleeplessness				
Unusual tiredness / Fatigue				
Irritability				
Depression				
Anxiety / Tension / Nervousness				
Mood Swings / Mood Changes				
Confusion / Difficulty Concentrating				
Forgetfulness / Short-term memory loss				
Angry outbursts / Arguments / Violent tendencies				
Crying easily				
Backache				
Joint pains				
Muscle pains				

Symptom	1	2	3	4
Muscle cramps / spasms				
Problems with wound healing times				
Acne / pimples / Skin flushing				
Dry skin / Dry Hair				
Crawling feeling under skin				
Frequent Urinary Tract Infections (UTI)				
Urinary frequency				
Vaginal dryness				
Abnormal bleeding				
Pelvic pain, pressure, fullness, or bloating				
Uncomfortable intercourse				
Loss of sexual feeling / desire				
Loss of arousability and capacity for orgasm				
Loss of sexual sensitivity				
Loss of vitality				
Nipple sensitivity				
Discharge or leaking from nipples				
Breast tenderness				
Loss of pubic hair				
Swelling of hands, ankles, or breasts				
Heart palpitations				
Shortness of breath				
Food/sweets/salt cravings				
Increased appetite / weight gain				