Wasatch Pharmacy Care
4387 Harrison Blvd. Suite D-7 Ogden, Utah 84403
Christine R. Jacobson R.Ph

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:

Name:_____ Age:_____ Birhtdate:_____
Address:_____
Home Phone No:_____ Work:_____ Cell:_____
Email address:_____ May I have permissions to email you?_____
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_____
physician/health care professional_____ books/articles_____ other_____
Do you understand what Natural Hormone Replacement is:_____
What are your goals for Natural Replacement?_____
_____
_____

MEDICAL STATUS:

General Health: excellent____ good____ fair____ poor____ Height:_____ Weight:_____
Current Diagnosis or medical conditions:_____
_____
_____
_____
Drug allergies:_____
_____
Allergies to food, pollens, etc.:_____
_____

801-479-0331
Fax: 801-479-0332

Current Medication: _____

_____

Current Vitamins or OTC products: _____

_____

Current Herbs/etc.: _____

_____

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: _____ Previously: _____ How Long: _____

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.:_____

_____

Please list family members who died of important diseases (see above 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? _____

Hormone Replacement Therapy Patient Information Sheet

Name_____

Have you experienced any of the following symptoms recently? Please circle the number that best describes your experiences, with one being Extremely Mild and ten being Extremely Severe.

Sleep Disruptions	1	2	3	4	5	6	7	8	9	10
Fatigue	1	2	3	4	5	6	7	8	9	10
Vaginal Dryness	1	2	3	4	5	6	7	8	9	10
Irritability	1	2	3	4	5	6	7	8	9	10
Nervousness	1	2	3	4	5	6	7	8	9	10
Breast Tenderness	1	2	3	4	5	6	7	8	9	10
Hot Flashes	1	2	3	4	5	6	7	8	9	10
Dry Skin	1	2	3	4	5	6	7	8	9	10
Mood Swings	1	2	3	4	5	6	7	8	9	10
Arthritis	1	2	3	4	5	6	7	8	9	10
Loss of Recent Memory	1	2	3	4	5	6	7	8	9	10
Weight Gain	1	2	3	4	5	6	7	8	9	10
Decreased Sex Drive	1	2	3	4	5	6	7	8	9	10
Depression	1	2	3	4	5	6	7	8	9	10
Fluid Retention	1	2	3	4	5	6	7	8	9	10
Headaches	1	2	3	4	5	6	7	8	9	10
Night Sweats	1	2	3	4	5	6	7	8	9	10
Hair Loss	1	2	3	4	5	6	7	8	9	10
Harder to Reach Climax	1	2	3	4	5	6	7	8	9	10
Bladder Symptoms	1	2	3	4	5	6	7	8	9	10
Other:	1	2	3	4	5	6	7	8	9	10

_____

Question Documentation Form

Please write down any questions you may have about Prescription Natural Hormone Replacement Therapy (Rx NHRT), other medications, or any other questions that come up as you read through the materials you have received. Bring this question sheet with you to your consultation so you can discuss this information with your pharmacist/nurse. Thank you.

1.

2.

3.

4.

5.

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Pharmacy Record Release Authorization

I, undersigned patient, authorize my pharmacist to release my personal medication and /or other medical information to the following persons or organizations upon request or as deemed necessary:

Name	Address	Telephone
1)		
2)		
3)		

I understand that employees of _____ Pharmacy will protect my privacy and this information will be released to other health care professionals only when it is necessary in order to provide health care services to me. This authority shall continue until revoked by me in writing.

Patient Name: _____

Address: _____

City,State,Zip: _____

Phone: _____

Signature: _____

Date: _____

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