WASATCH
PHARMACY CARE

1028 Chambers St, South Ogden, UT 84403 P: 801-479-0331 F: 1-855-273-1877

Christine R. Jacobson-Ware - RPh, DAAFM

Functional Medicine - Confidential Evaluation

From a clinical management point of view, it is very useful to gain a detailed history of possible hormone and chemical deficiencies. The answers provided in the questions below will allow the clinician to maintain your medical history and will help in advising about current functional medical therapies. All information provided will be kept confidential.

GENERAL INFORMATION

Name:_____ Sex:_____ Birthdate:_____
Address:_____
Home Phone #:_____ Work: _____ Cell: _____
Email Address:_____ May I have permission to email you? ☐ Yes ☐ No
Occupation:_____ ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Other

Living Situation: ☐ Spouse ☐ Alone ☐ Partner ☐ Friend(s) ☐ Parent ☐ Children ☐ Other
Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Pets:_____
How did you hear about Natural Hormone Replacement Therapy? ☐ Ad ☐ Another Patient
☐ Physician/healthcare professional ☐ Books/Articles ☐ Other_____
Do you understand what Natural Bioidentical Hormone Replacement is? ☐ Yes ☐ No ☐ I'm not sure
What are your goals for being healthy?

_____
_____
_____

MEDICAL STATUS

Your Age:_____ What age do you feel?_____
General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Height:_____ Weight:_____
Current diagnosis or medical conditions: _____
_____
_____
_____
Drug Allergies:_____
_____
Allergies to food, pollens, etc:_____
_____
Do you have: ☐ Lactose intolerance ☐ Gluten allergy ☐ Dairy allergy

Current Prescriptions	Purpose	Dose	How long used	How it is taken	Time of day
Current OTC Meds	Purpose	Dose	How long used	How it is taken	Time of day
Current Vitamins/Herbs	Purpose	Dose	How long used	How it is taken	Time of day

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 provider(s):_____

_____

PAST MEDICAL CONDITIONS

Childhood diseases:_____

☐ Heart trouble ☐ Stroke ☐ Epilepsy ☐ Asthma ☐ Cancer
☐ Kidney trouble ☐ Varicose veins ☐ Fractures ☐ Chronic fatigue ☐ Autoimmune
☐ Gallbladder trouble ☐ Clotting defects ☐ Arthritis ☐ Fibromyalgia
☐ High blood pressure ☐ Diabetes ☐ Colitis ☐ Eating disorder

STOMACH/BOWEL CONDITIONS

☐ Acid Reflux - rate from 1-10: _____ ☐ Gas ☐ Bloating ☐ Constipation ☐ Diarrhea
☐ IBS - list symptoms: _____

_____

HABITS

Dietary restrictions:_____
Meal choices - Breakfast:_____
Lunch:_____
Dinner:_____

Do you get routine physical exercise?_____ What type(s)?_____

Do you use: ☐ Tobacco How much:_____ Previously?_____ How long:_____

☐ Alcohol How much:_____ Previously?_____ How long:_____

☐ Caffeine How much:_____ Previously?_____ How long:_____

☐ CBD How much:_____ Previously?_____ How long:_____

☐ THC How much:_____ Previously?_____ How long:_____

☐ Other_____ How much:_____ Previously?_____ How long:_____

FAMILY HISTORY

Please list any family members who are still living, along with their age, who may have important diseases such as high blood pressure, heart disease, cancer, diabetes, osteoporosis, etc.:_____

_____

_____

_____

Please list family members who died from important diseases (listed above) and their age at time of death:

_____

_____

_____

GYNECOLOGICAL HISTORY

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

Date of last pelvic exam:_____ and pap smear:_____ Results:_____

Have you had an abnormal pap? ☐ Yes ☐ No Treatment: _____

Are you sexually active? ☐ Yes ☐ No Are you trying to get pregnant? ☐ Yes ☐ No

Current birth control method:_____ How long used:_____

Problems with it:_____ _____ How long:_____

Past birth control method and any related problems:_____

How many days from start of one period to start of next:_____ How long is your period:_____

How much bleeding:_____ Severity of cramps:_____

PMS symptoms:_____

PMS starts and ends when:_____

Current changes in your normal cycle_____

Bleeding between periods? ☐ Yes ☐ No When:_____

Current or past pelvic pain, pressure, or fullness? ☐ Yes ☐ No Describe:_____

Unusual vaginal discharge or itching? ☐ Yes ☐ No Describe:_____

Treatment:_____

Age at first pregnancy:_____ How many full term pregnancies:_____ Problems:_____

_____

Interrupted pregnancies (miscarriages/abortions):_____

_____

Postpartum depression/anxiety? ☐ Yes ☐ No

Have you had: ☐ Tubal ligation ☐ Part/whole ovary removal ☐ Hysterectomy - ☐ ovaries remain

☐ Uterine ablation

Please list dates of any Yes answers:_____

_____

CURRENT SYMPTOM PATIENT INFORMATION SHEET

Name:_____

Have you experienced any of the following symptoms recently? Please circle the number that best describes your experiences (**1 = EXTREMELY MILD, 10 = EXTREMELY SEVERE**)

Sleep disruptions.....	1	2	3	4	5	6	7	8	9	10
Fatigue/loss of energy.....	1	2	3	4	5	6	7	8	9	10
Decreased physical stamina/strength	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
Vaginal Dryness.....	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/joint pain.....	1	2	3	4	5	6	7	8	9	10
Body aches.....	1	2	3	4	5	6	7	8	9	10
Loss of recent memory.....	1	2	3	4	5	6	7	8	9	10
Brain fog.....	1	2	3	4	5	6	7	8	9	10
Weight gain.....	1	2	3	4	5	6	7	8	9	10
Decreased muscle mass.....	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
Decreased sex drive.....	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
Acne.....	1	2	3	4	5	6	7	8	9	10
Brittle nails.....	1	2	3	4	5	6	7	8	9	10
Extreme cold.....	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 have about the Functional Medicine Approach Therapy (Rx BHRT), other medications, or any other questions that come up as you read the materials you have received. Bring this sheet with you to your consultation so you can discuss this information with your pharmacist/clinician.

1. _____

2. _____

3. _____

4. _____

5. _____

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PHARMACY RECORD RELEASE AUTHORIZATION

I, the 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	PHONE

I understand that employees of _____ Pharmacy will protect my privacy and this information will be released to other healthcare professionals only when it is necessary in order to provide healthcare 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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