CONFIDENTIAL FEMALE HORMONE EVALUATION

Sinks Pharmacy • 1435 N. Main • St. Clair, MO 63077
Phone: 636-629-8085 • Fax: 636-629-8084

Today's Date: ____________________

Name: ____________________ **Birth date:** ____________ **Age:** ______

Address: ____
Street City State Zip

Phone: ____________________ **Email:** ____________________

Height: __________ **Weight:** __________ **Desired Weight:** __________

			How Often and How Much?
Do you use tobacco?	☐ Yes	☐ No	____________
Do you use alcohol?	☐ Yes	☐ No	____________
Do you use caffeine?	☐ Yes	☐ No	____________
Do you exercise?	☐ Yes	☐ No	____________

Allergies: Please list any allergies and describe the reaction that occurred

Drugs: ____

Foods: ____

Other: ____

Over-the-Counter Medication History: Please list all non-prescription medications that you are taking. (Include vitamins, herbals, and supplements): ____________________

Medical Conditions/Diseases: Please list any conditions/diseases that you have been diagnosed with or suffer from. (Examples include: heart disease, high blood pressure, depression, ulcers, arthritis, insomnia, etc.)

Current Prescription Medications (include hormones):

Medication Name and Strength	Date Started	How Often per Day

Patient Name: ______________________________

<u>List Hormones Previously Taken</u>: Date Started Date Stopped Reason

____

____

____

____

Have you ever used oral contraceptives (birth control)? ☐ Yes ☐ No

If you experienced any problems, please describe: ______________________________

____

How any pregnancies have you had? ________ How many children? ________

Any interrupted pregnancies? ☐ Yes ☐ No

If yes, please explain: ______________________________

Have you had a tubal ligation? ☐ Yes ☐ No If yes, date of surgery: ____________

Have you had a hysterectomy? ☐ Yes ☐ No If yes, date of surgery: ____________

Reason: ______________________________ Do your ovaries remain? ☐ Yes ☐ No

Do you have a family history of any cancers or osteoporosis? Please list the family member(s):

____

____

____

Have you had any of the following tests performed?

Mammography	☐ Yes	☐ No	Date: ____________	Outcome: ____________
PAP Smear	☐ Yes	☐ No	Date: ____________	Outcome: ____________
Bone Density	☐ Yes	☐ No	Date: ____________	Outcome: ____________

What age did your period start? __________ How many days is/was your cycle (example: 28): __________

Is/was your menstrual flow heavy or light? ____________________ Any clots? ☐ Yes ☐ No

Have you ever had what YOU would consider to be abnormal cycles? ☐ Yes ☐ No

Explain: ______________________________

____

____

When was your last period? __________ How many days did it last? ____________

Do you or have you ever suffered from Premenstrual Syndrome (PMS) symptoms? ☐ Yes ☐ No

Explain: ______________________________

____

Patient Name: ____________________

	Absent	Mild	Moderate	Severe
Hot Flashes	______	______	______	______
Night Sweats	______	______	______	______
Vaginal Dryness	______	______	______	______
Incontinence	______	______	______	______
Bleeding Changes	______	______	______	______
Fibrocystic Breast	______	______	______	______
Weight Gain	______	______	______	______
Fluid Retention	______	______	______	______
Dry Skin/Hair	______	______	______	______
Hair Loss	______	______	______	______
Anxiety	______	______	______	______
Depression	______	______	______	______
Mood Swings	______	______	______	______
Irritability	______	______	______	______
Headaches	______	______	______	______
Breast Tenderness	______	______	______	______
Cramps	______	______	______	______
Difficulty Falling Asleep	______	______	______	______
Difficulty Staying Asleep	______	______	______	______
Fatigue	______	______	______	______
Loss of Memory	______	______	______	______
Foggy Thinking	______	______	______	______
Acne	______	______	______	______
Arthritis	______	______	______	______
Decreased Sex Drive	______	______	______	______
Harder to Reach Climax	______	______	______	______
Stress	______	______	______	______

Other: ____

Patient Name: ________________________________

What are your goals for taking Hormone Replacement Therapy?

1. ____

2. ____

3. ____

Doctor that we should contact for this therapy: ________________________________

Name: ________________________ **Phone:** ________________________

Address ____

Street City State Zip

*** * * Please include a copy of all relevant lab work, especially hormone levels that you have recently obtained.**

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