Confidential Female Hormone Follow up Evaluation

Pharmacy Solutions
5750 Hidcote Dr. Lincoln, NE 68516
Toll Free: 888.890.6521
Fax: 402.486.4286
402.486.3383

Evaluation must be returned at least two days prior to your consult or you may be asked to reschedule your appointment!!

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.

Medical History

Name: _____ Birth date: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ _____ E-mail Address: _____
(primary) (secondary) (optional)

Occupation: _____

Height: _____ Weight: _____

Practitioner(s) currently seeing:
Name: Address: Phone:
_____
_____
_____

Current Prescription Medications (Star the Medications that have been added within the last 6 months):
Medication name Strength Date started How often per day
_____
_____
_____
_____
_____
_____

List any major stress, life changing events, or surgeries since visiting last:_____

_____

List any positive changes since visiting last:_____

_____

List any negative changes since consult:_____

_____

How are you currently using your hormones?:_____

_____

Have you had a hysterectomy? If so provide approximate date._____

Patient Symptoms

Rate your current status for each symptom by checking the appropriate modifier. Please feel free to use additional space to describe any symptoms. This section may be repeated upon subsequent visits.

Today's Date _____

***If you mark YES, please rank mild, moderate or severe**

SYMPTOM	Yes or No	1-Mild	2-Moderate	3-Severe
Fibrocystic Breast				
Nipple Sensitivity				
Breast Tenderness				
Heavy/Irregular Menses				
Breakthrough Bleeding				
Abnormal Bleeding				
Cramps				
Pelvic Pain				
Pelvic Pressure				
Pelvic Fullness				
Fluid Retention/Bloating				
Vaginal Dryness				
Bladder Symptoms				
Urinary Frequency				

Frequent Urinary Tract Infection (UTI)				
Harder to Reach Climax				
SYMPTOM	**Yes or No**	**1-Mild**	**2-Moderate**	**3-Severe**
Decreased Sex Drive				
Uncomfortable Intercourse				
Loss of Vitality				
New Facial Hair				
Dry Skin/Hair				
Weight Gain/Increased Appetite				
Food/Sweets/Salt Cravings				
Fluid Retention				
Hot Flashes				
Night Sweats				
Headaches				
Backaches				
Joint Pains				
Muscle Pains				
Arthritis				
Heart Palpitations				
Crawling Feeling Under Skin				
Swelling of Hands				
Swelling of Ankles				
Swelling of Breasts				
Tightness in Neck/Shoulders				

Depression				
Confusion/Difficulty Concentrating				
SYMPTOM	**Yes or No**	**1-Mild**	**2-Moderate**	**3-Severe**
Anxiety				
Mood Swings				
Crying Easily				
Angry Outbursts/Arguments/ Violent Tendencies				
Fatigue				
Loss of Memory				
Diminished Sense of Taste				
Decreased Vision				
Difficulty Falling Asleep				
Difficulty Staying Asleep				