# CONFIDENTIAL FEMALE HORMONE EVALUATION

**Today's Date:** ____________________

**Name:** _________________________________________ **Birthdate:** _________________ **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 (including hormones):

| Medication Name and Strength | Date Started | How Often per day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Patient Name:** ______________________________

List Hormones Previously Taken: Date Started Date Stopped Reason

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

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

If you experienced any problems, please describe: ______________________________________________

_____________________________________________________________________________

How many 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.

**PLEASE RETURN FORM TO**
**CREATIVE HEALTH PHARMACY OF DEWEY**

**524 E. DON TYLER AVE. DEWEY, OK 74029**
**OR EMAIL: POPKESS@DEWEYDRUG.COM**