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Female Hormone Patient Profile

Name: _____ Date: _____

Address:_____

Cell Phone: _____ Home Phone: _____ Work phone: _____

Email: _____

Drug Allergies:_____

Date of Birth: _____ Height: _____ Weight: _____

Name of Physician: _____ Phone #:_____

May we leave you a voice message? _____ Home _____ Cell

May we text message you when your medications are ready? ____Yes ____No
If yes, which company services your cell phone? (ex. Verizon, AT&T, etc.): _____

Which method of communication do you prefer? ____ Text Message ___ Email ____Voicemail

Do you have prescription insurance? ____Yes ____No
If yes, please provide a copy of the insurance card or bring it to the appointment.

Who referred you to us?_____

List of current medications (Include Supplements, OTC, and prescriptions):

_____
_____
_____
_____

Marital Status: ____Single ____ Married ____ Divorced ____ Widowed

Number of Pregnancies:_____ Number of Children: _____ Number of Miscarriages:_____

Do you take Calcium daily? ___Yes ___ No
If yes, how much? _____

Do you take Vitamin D daily? ___ Yes ___ No
If yes, how much? _____

Do you take Omega III (Fish Oil) daily? ___ Yes ___ No
If yes, please include the name/brand:_____

Name:_____

Please indicate which of the following supplements you have taken within the last 6 months;
Evening Primrose Oil (EPO), Chaste Tree Berry, Dong Quai, Black Chosh, Ginseng, Melatonin, etc.:

_____

_____

Lifestyle

Do you smoke? ___Yes ___No
If yes, how many per day? _____

Do you consume alcohol? ___ Yes ___No
If yes, how much? ____ Little ____ Moderate ____Excessive
If yes, what kind of alcohol? _____

How much caffeine do you consume per day? _____

Are you sexually active? ____ Yes ____ No
If yes, how often? _____ Sexual Orientation: _____

Is intercourse painful? ____ Yes ____ No

Do you use lubricants for intercourse? ____ Yes ____ No

Are you trying to get pregnant? ____ Yes ____ No

Have you been diagnosed with genital herpes? ____ Yes ____ No

Do you have lumpy breast? ____ Yes ____ No

Do you do monthly self breast exams? ____ Yes ____ No

Have you had a breast biopsy? ____ Yes ____ No

Do you exercise? ____ Yes ____ No
If yes, how many times per week do you exercise? _____
If yes, what kind of exercise? _____
If yes, do you do any upper body exercise? _____

What is your stress level? _____ Mild _____ Moderate _____ Severe

Medical History

Do you have any family history of cancer? ___Yes ___ No
If yes, what type of cancer and how they are related:

_____

_____

Is your mother deceased? _____ If yes, cause of death:_____

Name:_____

Is your father deceased? _____ If yes, cause of death:_____

Medical Conditions:

_____
_____
_____

Have you taken any hormones in the past? ___ Yes ___ No
If yes, please explain:

_____
_____

Have you had a Hysterectomy? ___ Yes ___ No
If yes, when? _____ Why? _____
If yes, do you still have your ovaries? ___ Yes ___ No

Please list any other past surgeries:

_____
_____

Have you had uterine ablation? ___ Yes ___ No

Date of your last Papsmear: _____ Normal results? ___ Yes ___ No

Date of your last mammogram: _____ Normal results? ___ Yes ___ No

Date of your last bone density test: _____ Normal results? ___ Yes ___ No

Please list your chief complaints:

_____
_____
_____
_____

Have you experienced any of the following symptoms within the last 6 months? Please circle the number that best describes your experience, **ONE** being minimal and **TEN** being extremely severe.

Name:_____

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
Nail Changes (Breaking/Peeling)	1	2	3	4	5	6	7	8	9	10
Mood Swings	1	2	3	4	5	6	7	8	9	10
Joint Pain	1	2	3	4	5	6	7	8	9	10
Loss of 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
Hard to Reach Climax	1	2	3	4	5	6	7	8	9	10
Bladder symptoms (Frequency, Urgency, Leakage)	1	2	3	4	5	6	7	8	9	10

Pharmacists may not prescribe medications. Recommendations made by our pharmacists must be approved by the patient's prescriber. By signing below, I hereby acknowledge that the risks and benefits of hormone therapy have been explained to me and my questions have been answered.

Patient Signature: _____ Date:_____

Name:____

Name:____