

# South River Compounding Pharmacy, Inc.

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South River  
compounding pharmacy

## Female Confidential Evaluation

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.

### GENERAL INFORMATION

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Occupation: \_\_\_\_\_ Full-time: \_\_\_ Part-time: \_\_\_ Retired: \_\_\_ Unemployed: \_\_\_ Other: \_\_\_

Living Situation-Spouse: \_\_\_ Alone: \_\_\_ Partner: \_\_\_ Friend(s): \_\_\_ Parents: \_\_\_ Children: \_\_\_ Other: \_\_\_

Marital Status- Married: \_\_\_ Single: \_\_\_ Divorced: \_\_\_ Widowed: \_\_\_

Pets: \_\_\_\_\_

How did you hear about Natural Hormone Replacement Therapy- Ad: \_\_\_ Another Patient: \_\_\_ Courses/  
Seminars: \_\_\_ Physician/Healthcare Practitioner: \_\_\_ Books/Articles/Magazines: \_\_\_ Other: \_\_\_\_\_

Who/Where: \_\_\_\_\_

What are your goals for today's consultation?: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### PRESCRIPTION INSURANCE

Carrier: \_\_\_\_\_ ID#: \_\_\_\_\_

Group#: \_\_\_\_\_ Relationship to Cardholder: \_\_\_\_\_

Cardholder Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Have you had the following labs drawn recently, if so please list the levels:

Progesterone: \_\_\_\_\_

Total Estrogen: \_\_\_\_\_

Testosterone: \_\_\_\_\_

Sex Hormone Binding Globulin: \_\_\_\_\_

Thyroid: \_\_\_\_\_

DHEA: \_\_\_\_\_

Cortisol: \_\_\_\_\_

**MEDICAL STATUS**

Last Menstrual Period: \_\_\_\_\_

General Health- Excellent:\_\_\_ Good:\_\_\_ Fair:\_\_\_ Poor:\_\_\_ Height:\_\_\_\_\_

Current Weight:\_\_\_\_\_ Ideal Weight:\_\_\_\_\_

Current diagnosis or medical conditions:\_\_\_\_\_

Drug Allergies:\_\_\_\_\_

Allergies to food, pollens, etc.:\_\_\_\_\_

Current Medications:\_\_\_\_\_

Current Vitamins or OTC products:\_\_\_\_\_

Current Herbs/etc.:\_\_\_\_\_

Have you ever had your cholesterol level checked:\_\_\_ Date:\_\_\_\_\_ Results:\_\_\_\_\_

Have you ever had a mammogram:\_\_\_ Date:\_\_\_\_\_ Results:\_\_\_\_\_

Have you ever had a bone density scan:\_\_\_ Date:\_\_\_\_\_ Results:\_\_\_\_\_

Current/Recent Health Care Providers: PCP:\_\_\_\_\_

GYN:\_\_\_\_\_

Others:\_\_\_\_\_

**PAST MEDICAL CONDITIONS**

Childhood diseases:\_\_\_\_\_

Heart Trouble:\_\_\_\_\_ High Blood Pressure:\_\_\_\_\_ Stroke:\_\_\_\_\_ Varicose Veins:\_\_\_\_\_

Clotting Defects:\_\_\_ Diabetes:\_\_\_ Kidney Trouble:\_\_\_ Epilepsy:\_\_\_ Fractures:\_\_\_\_\_

Arthritis:\_\_\_ Colitis:\_\_\_ Gallbladder Trouble:\_\_\_ Asthma:\_\_\_ Chronic Fatigue:\_\_\_\_\_

Fibromyalgia:\_\_\_ Eating Disorder:\_\_\_ Cancer:\_\_\_\_\_

**HABITS**

Dietary Restrictions:\_\_\_\_\_

Meal Choices-Breakfast:\_\_\_\_\_

-Lunch:\_\_\_\_\_

-Dinner:\_\_\_\_\_

-Snacks:\_\_\_\_\_

Do you get routine physical exercise:\_\_\_ What type/frequency:\_\_\_\_\_

Do you use tobacco products:\_\_\_ How much:\_\_\_ Previously:\_\_\_ How long:\_\_\_\_\_

Do you use alcohol products:\_\_\_ How much:\_\_\_ Previously:\_\_\_ How long:\_\_\_\_\_

Do you use caffeine products:\_\_\_ How much:\_\_\_\_\_

How much water do you drink daily?\_\_\_\_\_

Stresses (family, work, self, etc.):\_\_\_\_\_

## **FAMILY HISTORY**

Please list family members and their age which are still living that may have important diseases such as: High Blood Pressure, Heart Disease, Cancer, Diabetes, Osteoporosis, etc.: \_\_\_\_\_

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Please list family members who died of important diseases (see above question) and their age at time of death: \_\_\_\_\_

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## **SYMPTOMS I**

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

	Absent	Mild	Moderate	Severe
1. Headaches	_____	_____	_____	_____
2. Frequently Ill	_____	_____	_____	_____
3. Anxiety	_____	_____	_____	_____
4. Swollen Breast	_____	_____	_____	_____
5. Mood Swings	_____	_____	_____	_____
6. Fuzzy Thinking	_____	_____	_____	_____
7. Depression	_____	_____	_____	_____
8. Food Cravings	_____	_____	_____	_____
9. Irritability	_____	_____	_____	_____
10. Bloating	_____	_____	_____	_____
11. Cramps	_____	_____	_____	_____
12. Emotional Swings	_____	_____	_____	_____
13. Painful Breasts	_____	_____	_____	_____
14. Weight Gain	_____	_____	_____	_____
15. Difficulty Staying Asleep	_____	_____	_____	_____
16. Difficulty Falling Asleep	_____	_____	_____	_____

## **SYMPTOMS II**

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

	Absent	Mild	Moderate	Severe
1. Hot Flashes	_____	_____	_____	_____
2. Shortness of Breath	_____	_____	_____	_____
3. Night Sweats	_____	_____	_____	_____
4. Inability to Concentrate	_____	_____	_____	_____
5. Vaginal Dryness	_____	_____	_____	_____
6. Dry Hair/Skin	_____	_____	_____	_____
7. Hair Loss	_____	_____	_____	_____
8. Anxiety	_____	_____	_____	_____
9. Nervousness	_____	_____	_____	_____
10. Feel Overwhelmed	_____	_____	_____	_____
11. Fuzzy Thinking	_____	_____	_____	_____
12. Short Term Memory Loss	_____	_____	_____	_____

13. Frequent Urinary Tract Infections	_____	_____	_____	_____
14. Heart Palpitations	_____	_____	_____	_____
15. Frequent Yeast Infections	_____	_____	_____	_____
16. Vaginal Shrinking	_____	_____	_____	_____
17. Loss of Pubic Hair	_____	_____	_____	_____
18. Painful Intercourse	_____	_____	_____	_____
19. Inability to Reach Orgasm	_____	_____	_____	_____

**SYMPTOMS III**

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

	Absent	Mild	Moderate	Severe
1. Energy crashes mid-afternoon	_____	_____	_____	_____
2. Fatigue, Lack of Energy	_____	_____	_____	_____
3. Craving for salty food	_____	_____	_____	_____
4. Exhausted Easily	_____	_____	_____	_____
5. Sensitive to changes in weather	_____	_____	_____	_____
6. Loss of Sex Drive	_____	_____	_____	_____
7. Dark circles under eyes	_____	_____	_____	_____
8. Wounds heal slowly	_____	_____	_____	_____
9. body tender/sensitive to touch	_____	_____	_____	_____
10. Feel puffy/swollen all over	_____	_____	_____	_____
11. Symptoms of Low Thyroid	_____	_____	_____	_____

- Have unusual fatigue unrelated to exertions?
- Feel chillier than others, often needing to wear socks to bed?
- Dress in layers because of needing to adjust to various temperatures?
- Have feelings of anxiety that sometimes lead to panic?
- Have trouble with weight, often eating lightly, yet still not losing a pound?
- Experience aches/pains in muscles/joints unrelated to trauma or exercise?
- Have increased problems with digestion or allergies?
- Feel mentally sluggish, unfocused, or unusually forgetful?
- Know of anyone in your family who has ever had a thyroid problem?
- Suffer from dry skin, or are prone to adult acne or eczema?
- Go through periods of depression, and/or lowered sex drive?
- Family history of diabetes, anemia, rheumatoid arthritis, early graying hair?
- Experience your hair as feeling like straw, dry and easily falling out?
- Have significant menopausal symptoms or migraine despite estrogen?
- Have a history of whiplash or other neck injuries?
- Have a history of significant exposure to chlorine, bromine, or fluoride?
- Feel utterly exhausted by evening, yet have trouble sleeping?
- Do you wake up tired?

If you would you like us to share this information with your physician, please initial\_\_\_\_\_

Please list which physicians:\_\_\_\_\_

Date:\_\_\_\_\_ Signature:\_\_\_\_\_

Since health information may change periodically, please notify your South River Compounding Pharmacy, Inc. pharmacist of any new medications (prescription and nonprescription), allergies, drug reactions or health conditions.

Your signature acknowledges your receipt of SRCP's [Notice of Privacy Practices](#) according to New Federal Government HIPAA Regulations (This notice describes how medical information about you may be used and disclosed). It does not acknowledge your agreement or any restrictions you may request regarding your Protected Health Information.