

South River Compounding Pharmacy, Inc.

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Bio-Identical Hormone Replacement Patient Questionnaire

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home phone: _____ Work phone: _____ E-mail: _____
 Primary Care Provider: _____ OB/GYN: _____
 Referred by: _____
 Date of birth: _____ Weight: _____ Height: _____ Waist Measurement: _____
 Hip Measurement: _____ Breast Measurement: _____ Frame: S M L
 Race/Ethnicity: (circle each that applies) Caucasian, Black, Other / Hispanic, Non-hispanic
Prescription Insurance Carrier: _____ ID# _____
 Group# _____ Cardholder name: _____
 Relationship to cardholder: _____ Employer: _____
Drug Allergies: _____
Food Allergies: _____
 List **All** Current Medications/Hormones and supplements:

What are your goals for Treatment? _____

Prior Surgeries/Date:

_____ Tubal Ligation: _____
 _____ Hysterectomy: _____
 _____ Ovarian cyst removal: _____
 _____ Myomectomy: _____
 _____ Female Reconstructive Surgery: _____

Current Diagnosis/Conditions:

_____ Endometriosis
 _____ Uterine fibroids
 _____ PMS
 _____ Fibrocystic Breast Disease
 _____ Cancer
 Other: _____

Please indicate which symptoms you are currently experiencing

1. Headaches	_____	_____	_____	_____
2. Frequently Ill	_____	_____	_____	_____
3. Anxiety	_____	_____	_____	_____
4. Swollen Breast	_____	_____	_____	_____
5. Mood Swings	_____	_____	_____	_____
6. Depression	_____	_____	_____	_____
7. Food Cravings	_____	_____	_____	_____
8. Irritability	_____	_____	_____	_____
9. Bloating	_____	_____	_____	_____
10. Cramps	_____	_____	_____	_____
11. Emotional Swings	_____	_____	_____	_____
12. Painful Breasts	_____	_____	_____	_____
13. Difficulty Staying Asleep	_____	_____	_____	_____
14. Difficulty Falling Asleep	_____	_____	_____	_____
	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. Nervousness	_____	_____	_____	_____
9. Feel Overwhelmed	_____	_____	_____	_____
10. Fuzzy Thinking	_____	_____	_____	_____
11. Short Term Memory Loss	_____	_____	_____	_____
12. Frequent Urinary Tract Infections	_____	_____	_____	_____
13. Heart Palpitations	_____	_____	_____	_____

14. Frequent Yeast Infections	_____	_____	_____	_____
15. Vaginal Shrinking	_____	_____	_____	_____
16. Loss of Pubic Hair	_____	_____	_____	_____
17. Painful Intercourse	_____	_____	_____	_____
18. Inability to Reach Orgasm	_____	_____	_____	_____
	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	_____	_____	_____	_____

Habits:

Do you use caffeine products? ___yes ___no
How much _____

Do you use tobacco products? ___yes ___no
How much _____

Do you use alcohol products? ___yes ___no
How much _____

Do you exercise routinely? ___yes ___no
How much _____

History:

Number of pregnancies _____

Age at first pregnancy _____

Age at first period _____

Number of births _____

Average number of days menstruating _____

Cardiac Complications _____

Average number of days in a normal cycle _____

Palpitations _____

Fibroids ___yes ___no

Shortness of breath _____

Blood Pressure ___high ___low

none _____

High Cholesterol ___yes ___no

other _____

Last Menstrual Period: _____

Bone Mineral Density: _____ OK _____ Low _____ Never Tested

Family History:

History of Heart Disease

History of Breast Cancer

_____ Mother

_____ Mother

_____ Father

_____ Sister

_____ Grandparent

_____ Aunt

_____ Sibling

_____ Grandmother

History of Fibroid

History of Osteoporosis

_____ Mother

_____ Mother

_____ Sister

_____ Father

_____ Grandmother

_____ Grandparent

Typical Daily Diet:

_____ Sibling

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Daily Water Intake: _____

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

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.