

South River Compounding Pharmacy, Inc.

2300 Robious Station Circle
Midlothian, VA 23113
Fax: 804-897-6449

3656 Mayland Ct
Richmond, VA 23233
Fax: 804-967-6449

(804) 897-6447 Toll Free: 1-888-879-7713

www.southernriverRx.com

Email: info@southernriverRx.com



South River
compounding pharmacy

HRT Follow-Up

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.

Name	Date	
Date of Birth	Phone-H	Phone-W
Address if new		
<hr/>		
<hr/>		
e-mail address	Current PCP	

1. At this point in my program, my primary goals and/or chief concerns are: _____

2. I complied with the protocol/plan designed for me at the last visit and take my supplements and prescriptions as scheduled:

- Everyday
- 75% of the time
- 50% of the time
- 25% of the time
- Rarely
- What challenges or obstacles keep you from following your plan and taking your supplements and prescriptions as scheduled? _____

- I feel that the protocol/plan I've been following has helped me improve:
- By 100%
- By 75%
- By 50%
- 25% or less, but have seen some positive change
- No improvement

- New symptoms: _____

3. I am currently exercising:

- Daily
- 5 times per week
- 3 times per week or less
- Type of exercise _____
- Duration of activity _____

4. I am currently getting a restful nights sleep: Yes _____ No _____

5. I am getting at least 20 minutes of relaxation each day: Yes _____ No _____

6. What stressors in your life may be contributing to your current state of health? _____

7. My daily diet usually includes:

- Breakfast
- AM snack
- Lunch
- PM snack
- Dinner
- Evening Snack

My appetite is:

- > poor
- > fair
- > good
- > very good
- > out of control

I need help with my diet yes _____ no _____

8. Since health information may change periodically, please notify us of any new medications, prescription and nonprescription, allergies, drug reactions or heath conditions. _____

If you've had the following labs drawn recently, please list the levels:

Progesterone: _____

Total Estrogen: _____

Testosterone: _____

Sex Hormone Binding Globulin: _____

Thyroid: _____

DHEA: _____

Cortisol: _____

MEDICAL STATUS

Last Menstrual Period: _____ Last Pap Test: _____ Last Mammogram: _____

General Health- Excellent: ___ Good: ___ Fair: ___ Poor: ___ Current Weight: _____

Current Medications: _____

Current Vitamins or OTC products: _____

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 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.