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FEMALE EVALUATION FOR CONSULTATION

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 us to maintain your medical history and will help in advising about current medical therapies. All information will be kept confidential.

PATIENT INFORMATION

Date ___/___/___

Name ________________________________ Date of Birth _______________ Age ______
Address ______________________________City/State/Zip_________________________
Home Ph ___________________Cell ph __________________Work Ph ________________
Email ___________________________________(only used by SRCP and not sold to other entities)

Circle or bold all that apply

Occupation_______________________________ FT PT Retired Unemployed
Marital Status - Married Single Divorced Widowed
Living Situation - Spouse Alone Partner Friend Parents Children Other
Pets - ____
Drug allergies/Food allergies/Environmental allergies- _____________________________
____

How did you hear about South River Compounding Pharmacy?

Advertisement	Courses/Seminars	Physician/Practitioner	Books/Magazines	Another Patient – who?

Primary Care MD ____________________ Your Ob/Gyn __________________________
Address ____________________________ Address ______________________________
Tel # _____________________________ Tel # ________________________________

INSURANCE

Insurance Company ______________________ ID# ______________________________
Policy Holder ___________________________ Group # _________________________

Do you have Prescription Insurance – example – Express Scripts, Caremark, Medco …
We will need to obtain a copy of your insurance card.

What are your goals for this consultation?

1.

2.

3.

Prescription preferences: pill_____ or cream_____ vaginal cream_____ or vaginal suppository____

CURRENT MEDICAL STATUS

Describe your health: ___ Excellent ___ Good ___ Fair ___ Poor _____
Height _________ Current Weight ________ Ideal Weight ________

Current diagnosis or medical conditions

	Endometriosis		PCOS
	Uterine fibroids		High blood pressure
	PMS		Dysmenorrhea
	Fibrocystic breast disease		Infertility
	Cancer		Other -

Current Medications: ______________________ ______________________________________
____ ______________________________________
____ ______________________________________

Current Vitamins/Herbs/OTC: _______________ ______________________________________
____ ______________________________________
____ ______________________________________

Recent Mammogram? ________Date________ Results _______________________________
Recent Cholesterol screen? ____ Date ________ Results _______________________________
Recent Bone Density scan? ____ Date ________ Results _______________________________
Recent Colonoscopy ? ________ Date ________ Results _______________________________
Recent Blood Pressure? _______Date_________ Results_______________________________

PAST MEDICAL CONDITIONS

Childhood diseases: ____

Check all boxes that apply

	heart disease		varicose veins		kidney trouble		arthritis		asthma		eating disorder		IBS
	high blood pressure		clotting defects		epilepsy		colitis		chronic fatigue syndrome		thyroid		elevated cholesterol
	stroke		diabetes		fractures		gallbladder		fibromyalgia		anemia		cancer

PRIOR SURGERIES & YEAR

	Hysterectomy do you have your ovaries?		Ovarian cyst removal	
	Myomectomy		Female reconstructive surgery	
	Tubal ligation -		Other:	

GYNECOLOGIC HISTORY

Date of Late Menstrual Period ___________ Avg days between cycles ____________
Days of flow ______ Bleeding *(circle)* light medium heavy Cramps *(circle)* none moderate severe
Premenstrual symptoms ____
Starting & Ending when ____
Any changes in your normal cycle? ____
Any bleeding between periods? ___________________ When? ________________________
Any pelvic pain, pressure or fullness? ______________ Describe _______________________
Any unusual vaginal discharge or itching? __________ Describe _______________________
Date of : Last Pelvic Exam _______ Last Pap Smear _________ Result _______________
Ever had an abnormal Pap? _______ Treatment _____________________________________
Are you sexually active? Yes No Are you trying to get Pregnant? Yes No
Current Birth Control ____________ How Long? ______ Any Problems? ________________
Age at first pregnancy _______ # of term pregnancies _______ Miscarriages/Abortions _____
Any problem with pregnancies? ____
Have you ever had a fertility work-up? ______________ Findings:_______________________

HABITS

Please List a brief example of a typical day's diet

breakfast	
snack	
lunch	
snack	
dinner	
snack	

Dietary Restrictions ____
Do you get routine physical exercise? _____ 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? _____________
Your stresses (family, work, yourself, etc) ____________________________________
____
____

FAMILY HISTORY

Indicate family members who are still living with these diseases –

	History Heart Disease	History Cancer	History Osteoporosis	History Diabetes
mother				
father				
sibling				
grandmother				
grandfather				
aunt				

Indicate family members who died of these diseases

	Age	Heart Disease	Cancer	Other – identify disease
mother				
father				
grandmother				
grandmother				
grandfathers				

SYMPTOMS I – Rate each symptom by checking the appropriate modifier. This section is repeated upon subsequent visits to monitor progress.

	ABSENT	MILD	MODERATE	SEVERE
Headaches				
Frequently ill				
Anxiety				
Mood swings				
Fuzzy thinking				
Depression				
Irritability				
Bloating				
Cramping				
Food cravings				
Emotional swings				
Painful/Swollen Breasts				
Difficulty Losing Gain				
Difficulty Falling Asleep				
Difficulty Staying Asleep				

SYMPTOMS II – Rate each symptom by checking the appropriate modifier. This section is repeated upon subsequent visits to monitor progress.

	ABSENT	MILD	MODERATE	SEVERE
Hot Flashes				
Shortness of Breath				
Night Sweats				
Inability to Concentrate				
Vaginal Dryness				
Dry Hair/Skin				
Hair Loss				
Anxiety				
Nervousness				
Feel Overwhelmed				
Heart Palpitations				
Fuzzy Thinking				
Short Term Memory Loss				
Frequent UTI’s				
Frequent Yeast Infections				
Vaginal Shrinking				
Loss of Pubic Hair				
Painful Intercourse				
Inability to Reach Orgasm				

SYMPTOMS III – Rate each symptom by checking the appropriate modifier. This section is repeated upon subsequent visits to monitor progress.

	ABSENT	MILD	MODERATE	SEVERE
Energy crashes mid-afternoon				
Fatigue, lack of energy				
Craving salty food				
Exhausted easily				
Sensitive to changes in weather				
Loss of Sex Drive				
Dark circles under eyes				
Wounds heal slowly				
Body tender/sensitive to touch				
Feel puffy/swollen all over				
Does your mind race at bedtime				

SYMPTOMS IV – Check the box if the statement applies to you.

- ◻ 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, 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, or early graying hair?
- ◻ Experience your hair as feeling like straw, dry and easily falling out?
- ◻ Have significant menopausal symptoms or migraine despite estrogen?
- ◻ Have 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?
- ◻ First morning temperature (before your feet hit the floor)?_________

If you would like us to share this information with your physician, please initial _____
Please list the physician name and phone # ___________________________________
____

Date ____________________ Signature ____________________________________

Your signature acknowledges your understanding of SRCP's Notice of Privacy Practices according to HIPAA regulations. It does not acknowledge your agreement or any restrictions you may have requested regarding your Protected Health Information.