Women's Consultation Form

Today's Date

MM / DD / YYYY

Date of Birth

MM / DD / YYYY

Name

First

Last

Address

Street Address

Address Line 2

City

State

Zip/Postal Code

Country

Contact Telephone Numbers

Home

Work

Cell

Email

Height

Weight

Desired Weight

Occupation

800 E. Melbourne Avenue • Melbourne, Florida 32901
Phone (321) 953-2004 • Fax (321) 953-2808
www.specialty-pharmacy.com

What is your greatest need or problem?
(List the most important; then list other issues in order of importance):

What are your goals for taking HRT?

Your current medical conditions or diagnoses:

Drug allergies:

Allergies to food, pollens, environment, etc.:

Names of ALL prescription medications, taken in last 6 months. Include strength and how you take them:

List hormones previously taken (including date started, date stopped and reason):

Indicate any herbal products you have taken (Evening Primrose Oil (EPO), Chaste Tree Berry, Dong Quai, Black Cohosh Ginseng, Melatonin, etc.):

Names of ALL vitamins, supplements, non-prescription medicines, or other OTC products that you are currently using:

If you are currently taking medications for a thyroid condition, which one and dose?

Have you ever had a bone density scan? ☐ Yes ☐ No

When?	
Results:	

Do you use tobacco products? ☐ Yes ☐ No

What?	
For how long?	

Do you use alcohol products? ☐ Yes ☐ No

What?	
How much?	
For how long?	

Do you use caffeine products? ☐ Yes ☐ No

What?	
How much?	

Do you use recreational drugs? ☐ Yes ☐ No

What?	
How much?	

Do you exercise? ☐ Yes ☐ No

How often?	

How much water do you drink in one day (24 hr)?

	☐ Glasses ☐ Ounces

Is your drinking water from:

☐ Home Well ☐ City Water ☐ Distilled Water ☐ Bottled Water ☐ Water Purifier

Dietary restrictions (such as salt, carbohydrates, milk products, red meat, etc.):

When was your last general medical exam?

MM / DD / YYYY

When was your last pelvic exam?

MM / DD / YYYY

Have you ever had an abnormal Pap? ☐ Yes ☐ No

When?	
Treatment?	

At what age was your First Period (menarche)?	
When was your most recent or last period (LMP)?	
Do you still have your period?	☐ Yes ☐ No
If yes, how many days from the start of one period to the start of the next?	
Number of days of flow:	
Amount of bleeding:	
Any clots?	☐ Yes ☐ No
Describe any cramping or pain you may have:	
Do you have pain at any other time in your cycle?	☐ Yes ☐ No
Where, when, how long?	
Any current changes in your normal cycle?	
Any bleeding between periods (IMB)?	☐ Yes ☐ No

When and describe:	
What were your periods like as a teenager?	
Have you ever had Premenstrual Symptoms (PMS)?	☐ Yes ☐ No
If yes, please describe:	
How long have you had PMS symptoms?	
Starting and ending when:	
If your periods have ever been difficult, irregular, or abnormal in any way, please describe:	
If you are currently having any pelvic pain, pressure or fullness, describe:	
Describe any recent unusual vaginal discharge or itching:	
Treatment for any of above:	

Have you had any of the following surgeries?

Tubes tied (tubal ligation)?		☐ Yes ☐ No	
When?		**At what age?**	
Uterus removed (hysterectomy)?		☐ Yes ☐ No	
When?			
Why?			
Ovaries removed (oophorectomy)?		☐ Yes ☐ No	
If yes or PART, why?			
When?			
Why?			

Were there any problems associated with the surgery or removal of any of these organs?	☐ Yes ☐ No
Has your doctor diagnosed menopause, or told you that you are in menopause?	☐ Yes ☐ No
Do you have a family history of any cancers or osteoporosis?	☐ Yes ☐ No
Please list the family member(s):	
If Yes, at what age?	
If at age 40 years or earlier, was Premature Ovarian Failure diagnosed?	☐ Yes ☐ No
Have you ever been pregnant?	☐ Yes ☐ No
Are you trying to get pregnant?	☐ Yes ☐ No
What was your age at your first pregnancy?	
How many times have you been pregnant (gravida)?	
How many pregnancies resulted in the birth of living children (para)?	
Were there any problems?	☐ Yes ☐ No
Any interrupted pregnancies (miscarriages or abortions)?	☐ Yes ☐ No
Current birth control method:	
How long:	
Any problems?	☐ Yes ☐ No
Have you ever used any of the following birth control methods?	
Oral Contraceptives (Birth Control Pills)	☐ Yes ☐ No
Total months/years used:	
Describe any side effects to Birth Control Pills:	
Intra-Uterine Device (IUD)?	☐ Yes ☐ No
Problems?	☐ Yes ☐ No
When was your last mammogram?	
Results:	
Do you examine your breasts monthly?	☐ Yes ☐ No
Have you ever experienced breast pain, discomfort, nipple discharge, or swelling other than when pregnant?	☐ Yes ☐ No
If yes, give details:	

Have you ever been diagnosed with lumps, fibroids, breast cancer, or similar breast conditions?	☐ Yes ☐ No

If your doctor has recently ordered lab tests or diagnostic procedures for you, please give details, including whether the test or procedure was performed, and the results:

SYMPTOMS

CHECK **ONE** BOX FOR EACH SYMPTOM which best describes how you have been feeling for the past 3 weeks.

0 = None (symptom not present)

1 = Mild (present but not distressing)

2 = Moderate (distressing, but not interfering with daily life)

3 = Severe (very distressing, interferes with daily life)

If you wish to add comments or details, please send by separate email to our pharmacy, indicating your first and last name in the email. Thank you.

Hot flashes	☐ 0	☐ 1	☐ 2	☐ 3
Night sweats	☐ 0	☐ 1	☐ 2	☐ 3
Light-headed feelings/dizziness	☐ 0	☐ 1	☐ 2	☐ 3
Headaches	☐ 0	☐ 1	☐ 2	☐ 3
Sleep disorders/Sleeplessness	☐ 0	☐ 1	☐ 2	☐ 3
Unusual tiredness/Fatigue	☐ 0	☐ 1	☐ 2	☐ 3
Irritability	☐ 0	☐ 1	☐ 2	☐ 3
Depression	☐ 0	☐ 1	☐ 2	☐ 3
Stress	☐ 0	☐ 1	☐ 2	☐ 3
Anxiety/Tension/Nervousness	☐ 0	☐ 1	☐ 2	☐ 3
Mood swings/Mood changes	☐ 0	☐ 1	☐ 2	☐ 3
Confusion/Difficulty concentrating	☐ 0	☐ 1	☐ 2	☐ 3
Forgetfulness/Short-term memory loss	☐ 0	☐ 1	☐ 2	☐ 3
Angry outbursts/Arguments/Violent tendencies	☐ 0	☐ 1	☐ 2	☐ 3
Crying easily	☐ 0	☐ 1	☐ 2	☐ 3
Backache	☐ 0	☐ 1	☐ 2	☐ 3
Joint pains	☐ 0	☐ 1	☐ 2	☐ 3
Muscle pains	☐ 0	☐ 1	☐ 2	☐ 3
Muscle cramps/spasms	☐ 0	☐ 1	☐ 2	☐ 3
Problems with wound healing time	☐ 0	☐ 1	☐ 2	☐ 3

Acne/Pimples/Skin flushing	☐ 0	☐ 1	☐ 2	☐ 3
New facial hair	☐ 0	☐ 1	☐ 2	☐ 3
Dry skin/Dry hair	☐ 0	☐ 1	☐ 2	☐ 3
Crawling feeling under skin	☐ 0	☐ 1	☐ 2	☐ 3
Frequent Urinary Tract Infection (UTI)	☐ 0	☐ 1	☐ 2	☐ 3
Urinary frequency	☐ 0	☐ 1	☐ 2	☐ 3
Vaginal dryness	☐ 0	☐ 1	☐ 2	☐ 3
Abnormal bleeding	☐ 0	☐ 1	☐ 2	☐ 3
Pelvic pain, pressure, fullness, or bloating	☐ 0	☐ 1	☐ 2	☐ 3
Uncomfortable intercourse	☐ 0	☐ 1	☐ 2	☐ 3
Loss of sexual feeling/desire	☐ 0	☐ 1	☐ 2	☐ 3
Loss of arousability & capacity for orgasm	☐ 0	☐ 1	☐ 2	☐ 3
Loss of vitality	☐ 0	☐ 1	☐ 2	☐ 3
Nipple sensitivity	☐ 0	☐ 1	☐ 2	☐ 3
Discharge or leaking from nipples	☐ 0	☐ 1	☐ 2	☐ 3
Breast tenderness	☐ 0	☐ 1	☐ 2	☐ 3
Loss of pubic hair	☐ 0	☐ 1	☐ 2	☐ 3
Swelling of hands, ankles, or breasts	☐ 0	☐ 1	☐ 2	☐ 3
Heart palpitations	☐ 0	☐ 1	☐ 2	☐ 3
Shortness of breath	☐ 0	☐ 1	☐ 2	☐ 3
Food/sweets/salt cravings	☐ 0	☐ 1	☐ 2	☐ 3
Increased appetite/weight gain	☐ 0	☐ 1	☐ 2	☐ 3
Visual disturbance or decreased vision	☐ 0	☐ 1	☐ 2	☐ 3
Difficulty hearing	☐ 0	☐ 1	☐ 2	☐ 3
Diminished sense of taste	☐ 0	☐ 1	☐ 2	☐ 3
Diminished sense of smell	☐ 0	☐ 1	☐ 2	☐ 3

Doctor that we should contact for therapy: **(Include doctor's name, full address and telephone number)**