

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.

General Patient Information

Date ___/___/___
Name _____ Date of Birth _____ Age _____
Address _____ City/State/Zip _____
Home Phone _____ Cell phone _____ Work Phone _____
Email _____ (only used by Rx3 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 Rx3 Compounding Pharmacy?:

Advertisement _____ Books/Magazines _____

Courses/Seminars _____ Another Patient _____

Physician/Practitioner _____

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 cream vaginal cream 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 Stroke Diabetes Elevated cholesterol
 Fractures Gallbladder Fibromyalgia Anemia
 Cancer Other: _____

Prior Surgeries & Year

Hysterectomy Ovarian cyst removal Myomectomy Female reconstructive surgery
 Do you have your ovaries? Y N 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

	Heart Disease	Cancer	Osteoporosis	Diabetes
Mother				
Father				
Sibling				
Grandmother (please indicate maternal or paternal)				
Grandfather (please indicate maternal or paternal)				
Aunt				
Uncle				

Indicate family members who died of these diseases

	Heart Disease	Cancer	Osteoporosis	Diabetes
Mother				
Father				
Sibling				
Grandmother (please indicate maternal or paternal)				
Grandfather (please indicate maternal or paternal)				
Aunt				
Uncle				

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?

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 Rx3'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.