

SPECIALTY PHARMACY

Natural Hormone Replacement Therapy Consult Questionnaire

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Name _____ DOB _____ Phone _____

Address _____ Height _____ Weight _____

Email Address _____

Consult Date _____ Physician's Name _____

Do you have prescription insurance? YES NO If yes, name of insurance _____

Occupation _____ Employer _____ Have you had gastric bypass? YES NO

Have you had a hysterectomy? YES NO When? _____ Reason for hysterectomy _____

What was removed? Ovaries Left Ovary Uterus All

Are you still having periods? YES NO Date of last period? _____ Are you periods regular? _____

Have you ever gone more than 4 months without a period? YES NO

What was the date of your last mammogram? _____ Date of last pap smear _____

List any female type of cancers or problems that you currently have or have had in the past? (ex. Fibrocystic disease, breast cancer, endometriosis) _____

Do you smoke or use tobacco currently? YES NO If so, how many packs per day? _____

Have you had gallbladder or digestive problems? YES NO Blood clots or clotting problems? YES NO

Have you had your cholesterol checked? YES NO If so, when? _____ Results _____

Have you ever had your bone density tested? YES NO If so, Results _____

FAMILY HISTORY – On your *mother's side* of the family, has there been any

- Gynecological or female cancers? YES NO
If yes, type of cancer and relation to you _____
- Osteoporosis such as hip fractures, dowagers hump, or easily broken bones?
YES NO If so, relation to you _____
- Heart attack? YES NO If yes, relation to you _____

MEDICAL HISTORY

List any allergies to medication you may have: _____

List any chronic medical conditions you currently have: (such as diabetes, thyroid, arthritis, etc.) _____

List all hormones you have tried: _____

List all prescription medications you currently take including your current hormones: _____

List all vitamin/herbal supplements that you take daily or occasionally: _____