

SPECIALTY PHARMACY

Natural Hormone Replacement Therapy Consult Questionnaire

*Stephen F. Skinner, R.Ph * Calah Merritt, Pharm.D * Brooke Matthews, PharmD * Melinda M. Briscoe, RN*

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

FAMILY HISTORY

- Heart attack or Heart Disease? YES NO If yes, relation to you _____
- Cancer? YES NO If yes, relation to you and type of cancer _____

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 any past medical conditions (cancer, heart attack, surgeries) _____

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: _____

Please indicate the symptoms you are experiencing :

	Rare			Occasional				Very Often			
BURNED OUT FEELING	1	2	3	4	5	6	7	8	9	10	
DECREASED MENTAL SHARPNESS	1	2	3	4	5	6	7	8	9	10	
DEPRESSED	1	2	3	4	5	6	7	8	9	10	
PROSTATE PROBLEMS	1	2	3	4	5	6	7	8	9	10	
DECREASED ERECTIONS	1	2	3	4	5	6	7	8	9	10	
DECREASED SEX DRIVE	1	2	3	4	5	6	7	8	9	10	
DECREASED MUSCLE MASS											
DECREASED STAMINA	1	2	3	4	5	6	7	8	9	10	
FATIGUE / LACK OF ENERGY	1	2	3	4	5	6	7	8	9	10	
IRRITABILITY	1	2	3	4	5	6	7	8	9	10	
TROUBLE CONCENTRATING	1	2	3	4	5	6	7	8	9	10	
DIFFICULTY SLEEPING	1	2	3	4	5	6	7	8	9	10	
STRESS	1	2	3	4	5	6	7	8	9	10	
ANXIETY	1	2	3	4	5	6	7	8	9	10	
WEIGHT GAIN	1	2	3	4	5	6	7	8	9	10	

