Kubat Compounding

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Natural Hormone Replacement Confidential Evaluation

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

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GENERAL INFORMATION

Date:_____

Name:_____ Age:_____ Birth date:_____

Address:_____

Home phone:_____ Work phone:_____

Occupation:_____ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Other ☐

Living Situation: Spouse ☐ Alone ☐ Partner ☐ Friend(s) ☐ Parents ☐ Children ☐ Other ☐

Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐

Pets:_____

How did you hear about Natural Hormone Replacement Therapy? Ad ☐ Another patient ☐

Courses/Seminars ☐ Physician/Healthcare practitioner ☐ Books/Articles ☐ Other ☐

Do you understand what Natural Hormone Replacement is?_____

_____

What are your goals for Natural Hormone Replacement?_____

_____

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MEDICAL STATUS

General Health: Excellent ☐ Good ☐ Fair ☐ Poor ☐ Height:_____ Weight:_____

Current diagnosis or medical conditions:_____

_____

Drug allergies:_____

_____

Allergies to food, pollen, etc:_____

_____

Current Medications:_____

_____

Current vitamins or OTC products:_____

_____

Current Herbs/etc:_____

_____

Have you ever had your cholesterol level checked? Yes ☐ No ☐ Date:_____ Results:_____

Have you ever had your Hemoglobin A1C checked Yes □ No □ Date:_____ Results: _____

Have you ever had a PSA test? Yes □ No □ Date:_____ Results: _____

Have you ever had a bone density scan? Yes □ No □ Date:_____ Results:_____

Current/Recent Health Care Providers:_____

_____

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PAST MEDICAL CONDITIONS

Childhood diseases:_____

Heart Trouble □ High Blood Pressure □ Stroke □ Varicose Veins □ Clotting Defects □

Diabetes □ Kidney Trouble □ Epilepsy □ Fractures □ Arthritis □ Colitis □ Cancer □

Gallbladder Trouble □ Asthma □ Chronic Fatigue □ Fibromyalgia □ Eating Disorder □

Psoriasis □ Eczema□

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HABITS

Dietary Restrictions:_____

Meal Choices: Breakfast:_____

Lunch:_____

Dinner:_____

Do you get routine physical exercise?_____ What type?_____

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?_____

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FAMILY HISTORY

Please list family member and their ages who are still living that may have important disease such as: High Blood Pressure, Heart Disease, Cancer, Diabetes, Osteoporosis, etc:_____

_____

_____

_____

Please list family members who died of important of important diseases (see previous question) and their age at the time of death:_____

_____

_____

SYMPTOMS I

Rate your current status for each symptom by checking the appropriate modifier. Please feel free to use additional space to describe any symptom. This section may be repeated upon subsequent visits.

		Absent	Mild	Moderate	Severe
1.		_____	_____	_____	_____
2.	Low Libido	_____	_____	_____	_____
3.		_____	_____	_____	_____
4.		_____	_____	_____	_____
5.		_____	_____	_____	_____
6.		_____	_____	_____	_____
7.		_____	_____	_____	_____
8.		_____	_____	_____	_____
9.		_____	_____	_____	_____
10		_____	_____	_____	_____
11.		_____	_____	_____	_____
12.		_____	_____	_____	_____
13.		_____	_____	_____	_____

SYMPTOMS II

Rate your current status for each symptom by checking the appropriate modifier. Please feel free to use additional space to describe any symptom. This section may be repeated upon subsequent visits.

	Absent	Mild	Moderate	Severe
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

CONSULTATION NOTES