Kubat Compounding

Phone: (402) 558-2474
Fax (402) 561-1252

11107 Mill Valley Rd.
Omaha, NE 68154

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 a Hemoglobin A1C test? Yes □ No □ Date:_____ Results:_____

Have you ever had a mammogram? 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:_____

_____

_____

GYNECOLOGICAL HISTORY

Age at first period:_____ Date of last period:_____

Date of last pelvic exam:_____ and Pap smear:_____ Results:_____

Have you ever had an abnormal pap?_____ Treatment:_____

Are you sexually active?_____ Are you trying to get pregnant?_____

Current birth control method:_____ How long:_____

Problem with it:_____ How long:_____

Past birth control and any related problems:_____

How many days from start of one period to the start of the next:_____

Number of days of flow:_____ Amount of bleeding:_____

Amount of cramps:_____

Premenstrual symptoms:_____

Starting and ending when:_____

Any current changes in your normal cycle:_____

Any bleeding between periods:_____ When:_____

Any pelvic pain, pressure or fullness?_____ Describe:_____

Any unusual vaginal discharge or itching?_____ Describe:_____

Treatment:_____

Age at first pregnancy:_____

How many full term pregnancies?_____ Problems:_____

_____

_____

Any interrupted pregnancies? (miscarriages or abortions)_____

_____

Have you had a tubal ligation?_____ When:_____

Have you had any part or whole ovary removed?_____ When:_____

Have you had a hysterectomy?_____ When:_____

Do your ovaries remain?_____

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. Headaches	_____	_____	_____	_____
2. Low Libido	_____	_____	_____	_____
3. Anxiety	_____	_____	_____	_____
4. Swollen Breast	_____	_____	_____	_____
5. Moodiness	_____	_____	_____	_____
6. Fuzzy Thinking	_____	_____	_____	_____
7. Depression	_____	_____	_____	_____
8. Food Cravings	_____	_____	_____	_____
9. Irritability	_____	_____	_____	_____
10 Insomnia	_____	_____	_____	_____
11. Cramps	_____	_____	_____	_____
12. Emotional Swings	_____	_____	_____	_____
13. Painful Breast	_____	_____	_____	_____
14. Weight Gain	_____	_____	_____	_____
15. Bloating	_____	_____	_____	_____
16. Inability to Concentrate	_____	_____	_____	_____

SYMPTOMS II

	Absent	Mild	Moderate	Severe
1. Hot Flashes	_____	_____	_____	_____
2. Shortness of breath	_____	_____	_____	_____
3. Night Sweats	_____	_____	_____	_____
4. Sleep disorders, Insomnia	_____	_____	_____	_____
5. Vaginal Dryness	_____	_____	_____	_____
6. Dry Hair/Skin	_____	_____	_____	_____
7. Hair Loss	_____	_____	_____	_____
8. Anxiety	_____	_____	_____	_____
9. Mood Swings	_____	_____	_____	_____
10. Headaches	_____	_____	_____	_____
11. Depression	_____	_____	_____	_____
12. Short Term Memory Loss	_____	_____	_____	_____
13. Frequent Urinary Tract Infections	_____	_____	_____	_____
14. Heart Palpitations	_____	_____	_____	_____
15. Frequent Yeast Infections	_____	_____	_____	_____
16. Vaginal Shrinking	_____	_____	_____	_____
17. Loss of Pubic Hair	_____	_____	_____	_____

18. Painful Intercourse _____ _____ _____ _____

19. Inability to Reach Orgasm _____ _____ _____ _____

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SYMPTOMS III

	Absent	Mild	Moderate	Severe
1. Water Retention, Enema	_____	_____	_____	_____
2. Fatigue, Lack of Energy	_____	_____	_____	_____
3. Breast Swelling	_____	_____	_____	_____
4. Fibrocystic Breast	_____	_____	_____	_____
5. Premenstrual Mood Swings	_____	_____	_____	_____
6. Loss of Sex Drive	_____	_____	_____	_____
7. Heavy or Irregular Menses	_____	_____	_____	_____
8. Uterine Fibroids	_____	_____	_____	_____
9. Cravings for Sweets	_____	_____	_____	_____
10. Weight Gain (Hips & Thighs)	_____	_____	_____	_____
11. Symptoms of Low Thyroid	_____	_____	_____	_____

CONSULTATION NOTES