J.J.'s Prescription Specialties

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Confidential Female Hormone Evaluation

Insurance billing available

Today's Date: _____

Name: _____ **Birthdate:** _____ **Age:** _____

Address: _____ _____ _____ _____
Street *City* *State* *Zip*

Phone: _____ **Email:** _____

Height: _____ **Weight:** _____ **Desired Weight:** _____

Do You:

			How Often and How Much:
Use Tobacco?	○ Yes	○ No	_____
Drink Alcohol?	○ Yes	○ No	_____
Consume Caffeine?	○ Yes	○ No	_____
Exercise?	○ Yes	○ No	_____

Allergies: Please list any allergies and describe the reaction that occured.

Drugs: _____
Food: _____
Other: _____

Over-the-Counter Medication History: Please list all non-prescription medications that you are taking. Include vitamins, herbals and supplements.

Medical Conditions/Diseases: Please list any conditions/diseases that you have been diagnosed with or suffer from. Examples: Heart disease, high blood pressure, depression, ulcers, arthritis, insomnia, etc.

Current Prescription Medications (including hormones):

Medication Name and Strength	*Date Started*	*How Often Per Day*

Patient Name: _____

List of Hormones Previously Taken:

Hormone Name	*Date Started*	*Date Stopped*	*Reason*

Have you ever used oral contraceptives such as birth control? ○ Yes ○ No

If you experienced any problems while taking oral contraceptives, please describe:

How many pregnancies have you had? _____ How many children? _____

Any interrupted pregnancies? ○ Yes ○ No

If yes, please explain: _____

Have you had a tubal ligation? ○ Yes ○ No If yes, date of surgery: _____

Have you had a hysterectomy? ○ Yes ○ No If yes, date of surgery: _____

If yes, explain reason: _____ Do your ovaries remain? ○ Yes ○ No

Do you have a family history of any cancers or osteoporosis? If so, please list family member(s):

Have you had any of the following tests performed:

Mammography? ○ Yes ○ No Date: _____ Outcome: _____

PAP Smear? ○ Yes ○ No Date: _____ Outcome: _____

Bone Density? ○ Yes ○ No Date: _____ Outcome: _____

At what age did your period start? _____ How many days is/was your cycle? (Ex: 28) _____

Is/Was your menstrual flow heavy or light? _____ Any clots? ○ Yes ○ No

Have you ever had what you would consider to be abnormal cycles? ○ Yes ○ No

If yes, please describe:

When was your last period? _____ How many days did it last? _____

Do you or have you ever suffered from Premenstrual Syndrome (PMS) symptoms? ○ Yes ○ No

If yes, please describe:

Patient Name: _____

	Absent	Mild	Moderate	Severe
Hot Flashes	○	○	○	○
Night Sweats	○	○	○	○
Vaginal Dryness	○	○	○	○
Incontinence	○	○	○	○
Bleeding Changes	○	○	○	○
Fibrocystic Breast	○	○	○	○
Weight Gain	○	○	○	○
Fluid Retention	○	○	○	○
Dry Skin/Hair	○	○	○	○
Hair Loss	○	○	○	○
Anxiety	○	○	○	○
Depression	○	○	○	○
Mood Swings	○	○	○	○
Irritability	○	○	○	○
Headaches	○	○	○	○
Breast Tenderness	○	○	○	○
Cramps	○	○	○	○
Difficulty Falling Asleep	○	○	○	○
Difficulty Staying Asleep	○	○	○	○
Fatigue	○	○	○	○
Loss of Memory	○	○	○	○
Foggy Thinking	○	○	○	○
Acne	○	○	○	○
Arthritis	○	○	○	○
Decreased Sex Drive	○	○	○	○
Harder to Reach Climax	○	○	○	○
Stress	○	○	○	○
Other: _____	○	○	○	○

What are your goals for taking Hormone Replacement Therapy?

1. _____
2. _____
3. _____

Doctor that we should contact for this therapy:

Name: _____ Phone: _____

Address: _____ _____ _____ _____
Street *City* *State* *Zip*

If you have recent lab work, especially hormone levels, please bring that with you to your consultation.

Once finished, please print the completed form and bring it with you to JJ's Prescription Specialties.