**Female**
**Hormonal Health**
**Evaluation Form**

Date:_____

FULMER 4Save PHARMACY
Professional Compounders
"Your Problem Solving Specialists"

For proper clinical management, a detailed medical history is useful. The answers provided will aid in assessing your hormonal health. Please answer every question as completely as possible as each one has a purpose to help determine the most beneficial cause of action. If more space is needed, please use the backs of these pages. **ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL** and is protected by federal HIPAA regulations.

**GENERAL INFORMATION**

Name:_____ Phone: Home:_____

Address:_____ Work:_____

_____ Cell:_____

City/St/Zip:_____ email:_____

Date of Birth:_____ Best time to call:_____

Occupation:_____ ☐ Full Time ☐ Part Time ☐ Retired ☐

I Am: ☐ Left Handed ☐ Right Handed

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

How did you hear about bioidentical hormone replacement therapy (BHRT)? _____

_____

If you had a referral, who referred you? _____

What are your goals for BHRT? _____

_____

_____

Have you discussed BHRT with your health care practitioner? ☐ Yes ☐ No

Are they willing to work with us to achieve your goals? ☐ Yes ☐ No

Name_____

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**MEDICAL INFORMATION**

Primary Healthcare Practitioner/Physician:_____
Address:_____ Phone:_____
_____ Fax:_____
Other Practitioners you see:_____
General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Height:_____ Weight:_____ Blood Type:_____
Bone Structure: ☐ S ☐ M ☐ L
Which best describes your body shape? ☐ Tall, thin, with small breasts ☐ In Between ☐ Short, voluptuous, with full breasts
Drug Allergies:_____
Allergies to foods, pollens etc.:_____
_____
Current medications you are taking and when you began: **(include vitamins, herbals, OTC's etc.)**

_____ _____
_____ _____
_____ _____
_____ _____

How do you generally respond to drugs (do you need a lot or a little)?_____

**CURRENT AND PAST MEDICAL CONDITIONS:**

**Please check all that apply.**
**Explain below as needed.**

| | Y | N | Date of Diagnosis | | Y | N | Date of Diagnosis |
|---|---|---|---|---|---|---|---|
| Heart Disease | | | | High Blood Pressure | | | |
| Stroke | | | | Varicose Veins | | | |
| Clotting Defects | | | | Diabetes | | | |
| Kidney Trouble | | | | Epilepsy | | | |
| Fractures | | | | Arthritis | | | |
| Colitis | | | | Gallbladder Trouble | | | |
| Irritable Bowel | | | | Asthma | | | |
| Ulcers | | | | Autoimmune Disorder | | | |
| Fibromyalgia | | | | Osteoporosis | | | |
| Chronic Fatigue | | | | Cancer | | | |
| Eating Disorders | | | | Liver Disease | | | |
| Migraine Headache | | | | Lupus | | | |
| Endometriosis | | | | Uterine Fibroids | | | |
| Fibrocystic Breasts | | | | Polycystic Ovarian Syn. | | | |

Additional Info:_____
_____

Name_____

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**SOCIAL HISTORY / LIFESTYLE CHOICES**

Dietary restrictions:_____

Meal Choices: Breakfast:_____

Lunch:_____

Dinner:_____

Do you get routine physical exercise? ☐ Yes ☐ No

If Yes: What type?_____

How often?_____

| | **Are you now using?** | | | | **Did you use them in the past?** | | | |
|---|---|---|---|---|---|---|---|---|
| | Y | N | How Much? | | How Long? | Y | N | When Stopped? |
| Tobacco | | | pks/day | | yrs | | | |
| Alcohol | | | drinks/day | | yrs | | | |
| Caffeine | | | drinks/day | | yrs | | | |
| Regular Soda | | | drinks/day | | yrs | | | |
| Diet Soda | | | drinks/day | | yrs | | | |

**FAMILY HISTORY**

Are you adopted? ☐ Yes ☐ No If YES, complete this section with information from only your birth mother's family.

**Indicate which family members have experienced the conditions listed below. Place the appropriate initials in any category that applies.**

(M) Mother
(F) Father
(B) Brother
(S) Sister
(A) Aunt
(U) Uncle
(SN) Son
(GF) Grandfather
(GM) Grandmother
(D) Daughter

| **Who?** | | **When?** | **Who?** | | **When?** |
|---|---|---|---|---|---|
| | Breast Cancer | | | High Blood Pressure | |
| | Female Organ Cancer | | | Osteoarthritis | |
| | Colon Cancer | | | Rheumatoid Arthritis | |
| | Osteoporosis | | | Heart Attack | Age: |
| | Thyroid Disease | | | Hysterectomy | Age: |
| | High Cholesterol | | | Stroke | Age: |

Additional Information:_____

_____

Name_____

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**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? ☐ Y ☐ N When?_____ How many?_____
Treatment:_____
Are you sexually active? ☐ Y ☐ N Are you trying to get pregnant? ☐ Y ☐ N

Current birth control method:_____ How long?_____
Problem with it:_____ How long?_____
Past birth control and related problems:_____
Have you ever been on birth control? ☐ Y ☐ N Brand:_____ How long?_____
Side Effects?_____

Are you still having menstrual cycles? ☐ Y ☐ N Are they regular? ☐ Y ☐ N
How do you generally feel during your cycle:
Days 1-6 (First few days after flow begins):_____
Days 7-14 (mid cycle):_____
Days 15-21 (post-ovulation):_____
Days 22-28 (last few days just before period):_____
Can you now, or could you ever feel when you would ovulate? ☐ Y ☐ N

How many days from the start of one period to the start of the next?_____
Number of days of flow:_____ Amount of bleeding:_____

Amount of cramping:_____
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:_____

Name_____

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**GYNECOLOGICAL HISTORY CONT.**

Age at first pregnancy:_____ How many full term pregnancies?_____ Boys:____ Girls:____
Problems:_____

How did you feel during the 2nd trimester when you were pregnant?_____
_____

Any interrupted pregnancies? Miscarriages: ☐ Y ☐ N Abortions: ☐ Y ☐ N
Which pregnancy?_____ How far along?_____
_____

Have you had a tubal ligation? ☐ Y ☐ N When?_____
Did cycle or symptoms change after?_____
_____

Have you had a hysterectomy? ☐ Y ☐ N When?_____
Why?_____
Symptoms change after hysterectomy?_____
_____

Have you had any part of ovary removed? ☐ Y ☐ N When?_____
Why?_____
Symptoms change after?_____
_____

Age mother in menopause?_____
_____

Do your daughters have any reproductive health issues?_____
_____

Name_____

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**GOALS AND ASSESSMENT**

**What 3 things would you most like to change:**

**1)**_____

_____

**2)**_____

_____

**3)**_____

_____

**Please circle your quality of life:**

**0 1 2 3 4 5 6 7 8 9 10**

Near Death In Heaven

**Please add any additional information you think is relevant:**_____

_____

_____

_____

_____

_____

_____

_____

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**SYMPTOM CHECKLIST**

Rate your current status for each symptom by circling the appropriate number. Feel free to describe any symptom you think warrants further explanation. Some symptoms are repeated to aid in our evaluation. This section may be repeated at future times.

**Please use the following scale to rate each symptom below:**

**0 Do not have 1 2 Mild 3 4 Moderate 5 Severe**

| | | | | | | |
|---|---|---|---|---|---|---|
| Mood swings | 0 | 1 | 2 | 3 | 4 | 5 |
| Weight gain in hips | 0 | 1 | 2 | 3 | 4 | 5 |
| Heavy Bleeding | 0 | 1 | 2 | 3 | 4 | 5 |
| Irregular bleeding | 0 | 1 | 2 | 3 | 4 | 5 |
| Headaches | 0 | 1 | 2 | 3 | 4 | 5 |
| Nervousness | 0 | 1 | 2 | 3 | 4 | 5 |
| Irritability | 0 | 1 | 2 | 3 | 4 | 5 |
| Anxiousness | 0 | 1 | 2 | 3 | 4 | 5 |
| Fibrocystic breasts | 0 | 1 | 2 | 3 | 4 | 5 |
| Uterine fibroids | 0 | 1 | 2 | 3 | 4 | 5 |
| Tender breasts | 0 | 1 | 2 | 3 | 4 | 5 |
| Water retention | 0 | 1 | 2 | 3 | 4 | 5 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Hot flashes | 0 | 1 | 2 | 3 | 4 | 5 |
| Night sweats | 0 | 1 | 2 | 3 | 4 | 5 |
| Vaginal dryness | 0 | 1 | 2 | 3 | 4 | 5 |
| Dry skin/hair | 0 | 1 | 2 | 3 | 4 | 5 |
| Heart palpitations | 0 | 1 | 2 | 3 | 4 | 5 |
| Frequent yeast infections | 0 | 1 | 2 | 3 | 4 | 5 |
| Painful intercourse | 0 | 1 | 2 | 3 | 4 | 5 |
| Harder to reach orgasm | 0 | 1 | 2 | 3 | 4 | 5 |
| Frequent urinary tract inf. | 0 | 1 | 2 | 3 | 4 | 5 |
| Difficulty falling asleep | 0 | 1 | 2 | 3 | 4 | 5 |
| Short term memory loss | 0 | 1 | 2 | 3 | 4 | 5 |
| Cries easily | 0 | 1 | 2 | 3 | 4 | 5 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Foggy thinking | 0 | 1 | 2 | 3 | 4 | 5 |
| Food cravings | 0 | 1 | 2 | 3 | 4 | 5 |
| Weight gain | 0 | 1 | 2 | 3 | 4 | 5 |
| Difficulty staying asleep | 0 | 1 | 2 | 3 | 4 | 5 |
| Cramps | 0 | 1 | 2 | 3 | 4 | 5 |
| Breakthrough bleeding | 0 | 1 | 2 | 3 | 4 | 5 |
| Increased clotting | 0 | 1 | 2 | 3 | 4 | 5 |
| Bloating | 0 | 1 | 2 | 3 | 4 | 5 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Thinning Skin | 0 | 1 | 2 | 3 | 4 | 5 |
| More aches & pains | 0 | 1 | 2 | 3 | 4 | 5 |
| Decreased muscle strength | 0 | 1 | 2 | 3 | 4 | 5 |
| Weak bladder | 0 | 1 | 2 | 3 | 4 | 5 |
| Vaginal dryness | 0 | 1 | 2 | 3 | 4 | 5 |
| Difficulty reaching climax | 0 | 1 | 2 | 3 | 4 | 5 |
| Loss of sex drive | 0 | 1 | 2 | 3 | 4 | 5 |
| Constantly tired/lack of energy | 0 | 1 | 2 | 3 | 4 | 5 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Cold body temp/chilly | 0 | 1 | 2 | 3 | 4 | 5 |
| Decreased strength | 0 | 1 | 2 | 3 | 4 | 5 |
| Hair loss | 0 | 1 | 2 | 3 | 4 | 5 |
| Dry, brittle hair | 0 | 1 | 2 | 3 | 4 | 5 |
| Change in nails | 0 | 1 | 2 | 3 | 4 | 5 |
| Constipation | 0 | 1 | 2 | 3 | 4 | 5 |
| Headaches | 0 | 1 | 2 | 3 | 4 | 5 |
| Depression | 0 | 1 | 2 | 3 | 4 | 5 |
| Weight gain in hips & thighs | 0 | 1 | 2 | 3 | 4 | 5 |
| Cold hands & feet | 0 | 1 | 2 | 3 | 4 | 5 |
| Fatique, tiredness | 0 | 1 | 2 | 3 | 4 | 5 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Sugar craving | 0 | 1 | 2 | 3 | 4 | 5 |
| Allergies | 0 | 1 | 2 | 3 | 4 | 5 |
| Stress | 0 | 1 | 2 | 3 | 4 | 5 |
| Chemical sensitivity | 0 | 1 | 2 | 3 | 4 | 5 |
| Heart palpitations | 0 | 1 | 2 | 3 | 4 | 5 |
| Cold body temperature | 0 | 1 | 2 | 3 | 4 | 5 |
| Weight gain in waist | 0 | 1 | 2 | 3 | 4 | 5 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Excessive facial/body hair | 0 | 1 | 2 | 3 | 4 | 5 |
| Increased acne | 0 | 1 | 2 | 3 | 4 | 5 |
| Oily skin | 0 | 1 | 2 | 3 | 4 | 5 |
| Sleep disturbances | 0 | 1 | 2 | 3 | 4 | 5 |

Name_____