CONFIDENTIAL FEMALE HORMONE EVALUATION

Today's Date: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____
Street City State Zip

Phone: _____ Email: _____

Height: _____ Weight: _____ Desired Weight: _____

Occupation: _____ Hobbies: _____

			How often and how much?
Do you use tobacco?	☐ Yes	☐ No	_____
Do you use alcohol?	☐ Yes	☐ No	_____
Do you use caffeine?	☐ Yes	☐ No	_____
Do you exercise?	☐ Yes	☐ No	_____
How long have you exercised? (months/years)			_____
Type of exercise preferred?			_____

			If yes, please elaborate (dates/frequency):
Have you ever had a panic attack?	☐ Yes	☐ No	_____
Do you have OCD?	☐ Yes	☐ No	_____
Any diagnosis of mental illness?	☐ Yes	☐ No	_____
Every had a head injury/concussion?	☐ Yes	☐ No	_____

How frequent are your bowel movements? _____

Typical # of hours of sleep per night: _____ Normal bedtime: _____

Uninterrupted? ☐ Yes ☐ No Time and reason for interruption: _____

Do you wake rested or tired (even when getting 7-8 hours of sleep)? _____

Are you or have you ever been a night shift worker? ☐ Yes ☐ No

If yes, please describe when and for how long: _____

My diet is:

_____ Super healthy

_____ Mostly healthy

_____ Needs work

_____ Terrible

What would you like to change about your current dietary choices? _____

_____

_____

Patient Name: _____

Allergies: Please list any allergies and describe the reaction that occurred.
Drugs: _____
Foods: _____
Other: _____

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

CBD/THC Use: Please list any products used and frequency:_____

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

Have you ever tested positive for Epstein-Barr virus? ☐ Yes ☐ No
If yes, please elaborate (dates/current status): _____

Current Prescription Medications (including hormones):

Medication Name and Strength	Date Started	How Often per Day	Medical Condition Being Treated
_____			
_____			
_____			
_____			
_____			

List Hormones Previously Taken:

	Date Started	Date Stopped	Reason
_____			
_____			
_____			
_____			

Have you ever used oral contraceptives (birth control)? ☐ Yes ☐ No
If you experienced any problems, please describe: _____
_____

Patient Name: _____

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

Any interrupted pregnancies? ☐ Yes ☐ No

If yes, please explain:_____

If you have been pregnant, how did you feel while pregnant? Please explain (ex: great, horrible, to be expected) _____

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: _____

Reason for hysterectomy/diagnosis: _____

Do your ovaries remain? ☐ Yes ☐ No

Have you had an endometrial ablation? ☐ Yes ☐ No If yes, date of surgery: _____

Date of COVID infection/vaccine: _____

Do you have a family history of any cancers or osteoporosis? Please list the 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: _____

What age did your period start? _____ How many days is/was your cycle (Example: 28): _____

Is/was your menstrual flow heavy or light? _____ Any clots? ☐ Yes ☐ No

At what age (if known) did your mother, maternal aunts, sisters go through menopause?

_____

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

Explain: _____

_____

_____

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

Explain: _____

_____

_____

Patient Name: _____

Hot Flashes

# of times/day AM _____ Mid-day _____ PM _____ ALL DAY _____

Intensity of each time of day (label each time of day as mild, moderate or severe):

_____ _____ _____ _____

	Absent	Mild	Moderate	Severe
Night Sweats	_____	_____	_____	_____
Describe	_____			
Vaginal Dryness	_____	_____	_____	_____
Describe	_____			
Incontinence	_____	_____	_____	_____
Describe	_____			
Bleeding Changes	_____	_____	_____	_____
Describe	_____			
Fibrocystic Breast	_____	_____	_____	_____
Describe	_____			
Weight Gain	_____	_____	_____	_____
Describe	_____			
Fluid Retention	_____	_____	_____	_____
Describe	_____			
Dry Skin/Hair	_____	_____	_____	_____
Describe	_____			
Hair Loss	_____	_____	_____	_____
Describe	_____			
Anxiety	_____	_____	_____	_____
Describe	_____			
Depression	_____	_____	_____	_____
Describe	_____			
Mood Swings	_____	_____	_____	_____
Describe	_____			

Patient Name: _____

	Absent	Mild	Moderate	Severe
Irritability	_____	_____	_____	_____
Describe	_____			
Headaches	_____	_____	_____	_____
Describe	_____			
Breast Tenderness	_____	_____	_____	_____
Describe	_____			
Cramps	_____	_____	_____	_____
Describe	_____			
Difficulty Falling Asleep	_____	_____	_____	_____
Describe	_____			
Difficulty Staying Asleep	_____	_____	_____	_____
Describe	_____			
Fatigue	_____	_____	_____	_____
Describe	_____			
Loss of Memory	_____	_____	_____	_____
Describe	_____			
Foggy Thinking	_____	_____	_____	_____
Describe	_____			
Acne	_____	_____	_____	_____
Describe	_____			
Arthritis	_____	_____	_____	_____
Describe	_____			
Decreased Sex Drive	_____	_____	_____	_____
Describe	_____			
Harder to Reach Climax	_____	_____	_____	_____
Describe	_____			
Stress	_____	_____	_____	_____
Describe	_____			
Sugar Cravings	_____	_____	_____	_____
Describe	_____			

Patient Name: _____

	Absent	Mild	Moderate	Severe
Excess Facial/Body Hair	_____	_____	_____	_____

Describe _____

Other Symptoms:

_____

_____

What are your goals for taking Hormone Replacement Therapy?

1. _____
2. _____
3. _____

When in your lifetime did you feel the best? (please explain with details)

_____

_____

_____

Doctor who we should contact for this therapy:

Name: _____ Phone: _____

Address: _____

Street City State Zip

*** Please include a copy of all relevant lab work, especially hormone levels that you have recently obtained.

Rye Beach Pharmacy

Over 75 years of Nurturing Optimal Health

PATIENT INFORMATION

NAME:_____ PHONE #_____

ADDRESS:_____

CITY:_____ STATE:_____ZIP:_____

D.O.B._____ AGE:_____ GENDER: _____

MARITAL STATUS: SINGLE, MARRIED, DIVORCED OR WIDOW (CIRCLE ONE)

REFERRED BY:_____

PATIENT CONSENT

I understand that balancing the endocrine (hormonal) system is an essential element in achieving a better state of health. This goal can only be achieved through a professional triage consisting of; a certified hormone specialist, a licensed medical doctor and me, the patient.

I understand that Rosella Menta, R.Ph is not a medical doctor, but a hormone specialist. Rye Beach Pharmacy and all such representatives of which, only assess disease states and will not diagnose diseases or prescribe medications. In doing so, may use unconventional approaches to disease management that some healthcare practitioners may not agree with.

I understand that hormonal balance is our goal which will take time and cooperation between qualified practitioners and I. There might be a need to adjust strengths of medications used, dosage forms or a change in treatment, which can take 4 to 6 months or longer if necessary.

Print:_____ Signature:_____

Date:_____

Consultation Fee: Initial $175 for 1 hour, follow-ups can be ½ hour at $100. Prorated if longer

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