COMPOUNDING CENTER Rx
by Medicine Man

FEMALE HORMONE EVALUATION FORM

Please rate each symptom you are experiencing on a scale from 1 to 5, where 1 is very mild and 5 is very severe. Leave blank if you are not experiencing the symptom.

RATING SCALE:

- **0 – no symptom**
- **1 – very mild**
- **2 – mild**
- **3 – moderate**
- **4 – severe**
- **5 – very severe**

SYMPTOMS	RATING
ACNE	Choose an item.
ANXIETY/NERVOUSNESS	Choose an item.
APATHY	Choose an item.
BREAST TENDERNESS	Choose an item.
BRITTLE NAILS	Choose an item.
BURNED-OUT FEELING	Choose an item.
CHEMICAL SENSITIVITIES	Choose an item.
COLD BODY TEMPERATURE	Choose an item.
COLD EXTREMITIES	Choose an item.
CONFUSION	Choose an item.
CONSTIPATION	Choose an item.
ABDOMINAL CRAMPING	Choose an item.
CRAVINGS FOR SWEET	Choose an item.
DECREASED CONCENTRATION	Choose an item.
DECREASED SEX DRIVE	Choose an item.
DECREASED SEXUAL SENSATION	Choose an item.
DECREASED STAMINA	Choose an item.
DEEPENING OF VOICE	Choose an item.
DEPRESSED MOOD	Choose an item.
DRY EYES	Choose an item.

DRY SKIN/HAIR	Choose an item.
FATIGUE	Choose an item.
FIBROCYSTIC BREASTS (PAIN, TENDERNESS OR FIRMNESS)	Choose an item.
FLUID RETENTION IN ABDOMEN	Choose an item.
FLUID RETENTION IN EXTREMITIES	Choose an item.
FOGGY THINKING	Choose an item.
HEADACHES	Choose an item.
HEART PALPITATIONS	Choose an item.
HEAVY AND IRREGULAR MENSES	Choose an item.
HOARSENESS	Choose an item.
HOT FLASHES	Choose an item.
HYPOGLYCEMIA	Choose an item.
INCREASED FACIAL AND/OR BODY HAIR	Choose an item.
INCREASED HAIR LOSS	Choose an item.
IRRITABILITY	Choose an item.
JOINT PAINS	Choose an item.
LOW BLOOD PRESSURE	Choose an item.
MEMORY PROBLEMS	Choose an item.
MOOD SWINGS	Choose an item.
MUSCLE PAIN	Choose an item.
NIGHT SWEATS	Choose an item.
NUMBNESS OF HANDS AND FEET	Choose an item.
PAINFUL INTERCOURSE	Choose an item.
PREMENSTRUAL SYNDROME	Choose an item.
SALT CRAVINGS	Choose an item.
SLEEP DISTURBANCES	Choose an item.
SWOLLEN EYES	Choose an item.
TEARFULNESS	Choose an item.
THINNING SKIN	Choose an item.
TIRED BUT WIRED	Choose an item.
URINARY INCONTINENCE	Choose an item.
VAGINAL DRYNESS	Choose an item.
WEIGHT GAIN: HIPS	Choose an item.

WEIGHT GAIN: WAIST	Choose an item.

NAME: Click or tap here to enter text.
DATE OF BIRTH: Click or tap to enter a date.
PHONE NUMBER: Click or tap here to enter text.
ADDRESS: Click or tap here to enter text.
ALLERGIES: Click or tap here to enter text.
FOOD INTOLERANCES: Click or tap here to enter text.

QUESTIONNAIRE

This section is intended to be generalized. Answer to the best of your ability. If any information is missing, we will discuss this at a further point during evaluation.

1. What issues are concerning you the most regarding your hormone treatment, symptoms, and evaluation?
   Click or tap here to enter text.
2. What are your current prescription and over-the-counter medications?

Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.
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3. What nutritional supplements are you taking?

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4. Have there been any changes in diet or exercise within the past 6 months?
   Click or tap here to enter text.

5. What does your diet look like from day to day?
   Click or tap here to enter text.

6. What, if any, is your exercise routine?
   Click or tap here to enter text.

7. What medical conditions do you have?
   Click or tap here to enter text.

8. Have you been diagnosed with any of the following medical conditions now or in the past (please select yes or no):

BLOOD CLOTS	Choose an item.
BREAST CANCER	Choose an item.
OTHER CANCER(S)	Choose an item.

(IF YES, PLEASE LIST TYPE(S)	Click or tap here to enter text.
STROKE	Choose an item.
HEART FAILURE	Choose an item.
HEART VALVE REPLACEMENT	Choose an item.
HEART SURGERY	Choose an item.
ATRIAL FIBRILLATION	Choose an item.
HIGH BLOOD PRESSURE	Choose an item.
OSTEOPOROSIS	Choose an item.
DIABETES	Choose an item.
PRE-DIABETES	Choose an item.
ADDISONS DISEASE	Choose an item.
CUSHINGS DISEASE	Choose an item.
HYPERALDOSTERONEISM	Choose an item.
HYPERTHYROID	Choose an item.
HYPOTHYROID	Choose an item.

9. Regarding your hormone therapy, are there any treatments you have tried in the past? Were they successful? Were there any that failed?
   Click or tap here to enter text.
10. Do you still have menstrual cycles? Choose an item.
11. Are/were your cycles regular? Choose an item.
12. How many children have you given birth to? Choose an item.
13. Have you had tubal ligation? Choose an item.
    a. If so, when? Click or tap to enter a date.
14. Have you had a hysterectomy? Choose an item.
    a. If so, when? Click or tap to enter a date.
    b. Do your ovaries remain? Choose an item.
15. Do you have any other topics or concerns you would like to discuss with the pharmacist?
    Click or tap here to enter text.