STARK EDLER APOTHECARY

10600 Quivira Road
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Hormone Replacement Therapy Patient Information Sheet

Name:_____ Phone#:_____

Address:_____

Date of Birth:_____ Your Doctor:_____

Doctor's Phone#_____ Doctor's Fax#_____

Your main reason(s) for seeking care today. Please list most severe condition first.

1._____

2._____

3._____

MEDICAL HISTORY

Medication or food allergies:_____

_____

Are you currently taking hormones?_____ If so, what is your regimen?_____

_____

List any previous hormone therapy you have tried:_____

_____

List any other prescription medication you are currently taking:_____

_____

List any vitamin, nutritional, or natural products you are currently taking:_____

_____

Have you had any children?_____ Do you still have your uterus?_____ Ovaries?_____

Do you consume caffeinated drinks?_____If yes, how much?_____

Do you smoke? _____ If yes, how much? _____

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Please circle any of the following conditions you have had previously or currently.

Thyroid Disease	Fibrocystic Breast Disease	Endometriosis
Prematurely gray	Blood clotting disorder	Cancer
Heart Disease	Migraine headaches	Lupus
Osteoporosis	High blood pressure	Other:_____

Is there a family history of: Uterine cancer? Yes_____ No_____

Ovarian cancer? Yes_____ No_____

Breast cancer? Yes_____ No_____

Osteoporosis? Yes_____ No_____

Heart Disease? Yes_____ No_____

Do you still have your period?_____ If not, age at menopause or hysterectomy:_____

Are your cycles regular? Yes_____ No_____

Do you or did you have PMS Yes_____ No_____

Cramps? Yes_____ No_____

Are you currently taking birth control pills? Yes_____ No_____

If so, which one?_____

Have you experienced any of the following symptoms recently? (Circle all that apply)

Sleep disruption	Decreased libido (sex drive)	Night sweats
Depression	Fatigue	Fluid retention
Vaginal dryness	Migraines/headaches	Irritability
New facial hair	Nervousness	Breast tenderness
Hot flashes	Decreased quality of orgasm/intercourse	
Dry skin	Mood swings	Crying easily
Weight gain	Short-term memory loss	Painful intercourse
Poor concentration	Food cravings	Backaches

Other:_____

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Do you have any questions, comments, or concerns regarding natural hormone replacement therapy?

Pharmacists notes: