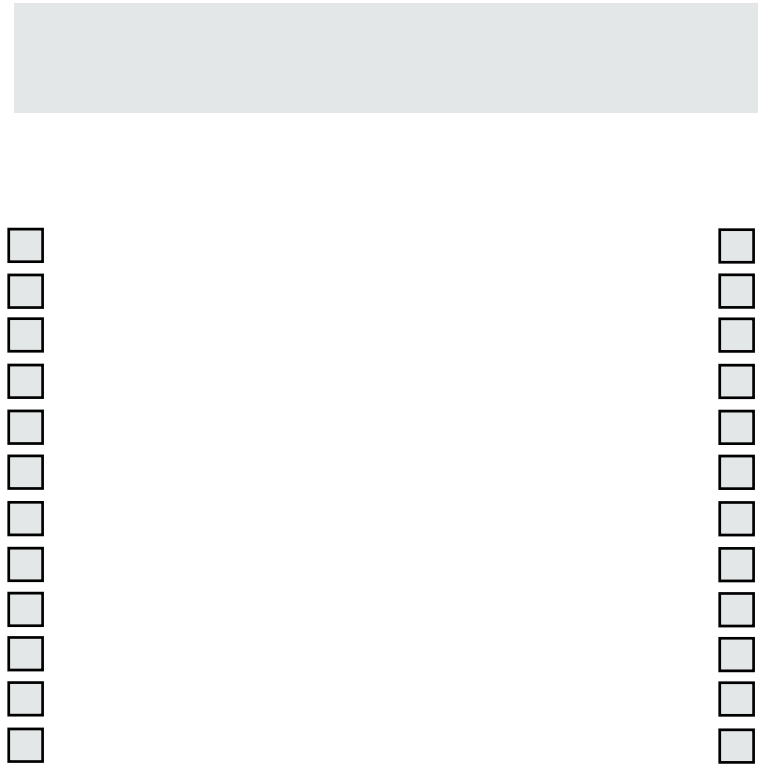


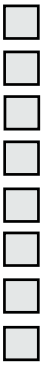

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Women's Hormone Consultation Questionnaire

Please fill out your information

TOWN & COUNTRY
Compounding Pharmacy
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Patient Medical Information

Age at first pregnancy

How many full-term pregnancies?

Any problems?

Any interrupted pregnancies? (miscarriages or abortions)

☐ Yes ☐ No

Have you had tubal ligation?

☐ Yes ☐ No

If so, when?

Have you had any part of whole ovary removed?

☐ Yes ☐ No

If so, when?

Please check any or all symptoms that apply

- ☐ Memory Lapse
- ☐ Incontinence
- ☐ Increased Urinary Urge
- ☐ Heart Palpitations
- ☐ Rapid Heart Beat
- ☐ Bleeding Cycle Changes
- ☐ Breast Tenderness
- ☐ Nervousness
- ☐ Emotional Instability
- ☐ Infertility Issues
- ☐ Decreased Libido
- ☐ Hearing Loss
- ☐ Decreased Stamina
- ☐ Low Blood Pressure
- ☐ High Blood Pressure
- ☐ Loss of Scalp
- ☐ Slow Pulse Rate
- ☐ Depression
- ☐ Puffy Eyes/Face
- ☐ Dry Skin
- ☐ Goiter
- ☐ Foggy Thinking
- ☐ Hot Flashes
- ☐ Cramps
- ☐ Thinning Skin
- ☐ Mood Swings
- ☐ Fluid Retention
- ☐ Weight Gain - Hips
- ☐ Weight Gain - Waist Anxiety
- ☐ Acne
- ☐ Allergies
- ☐ Aches and Pains
- ☐ Low Blood Sugar
- ☐ Rapid Aging
- ☐ Morning Fatigue
- ☐ Evening Fatigue
- ☐ Headaches
- ☐ High Cholesterol
- ☐ Dry or Brittle hair
- ☐ Constipation
- ☐ Decreased Sweating
- ☐ Bone Loss
- ☐ Stress
- ☐ Night Sweats
- ☐ Irritability
- ☐ Cravings for Salt
- ☐ Cravings for Sweets
- ☐ Vaginal/Urinary Tract Infection
- ☐ Insomnia (Falling Asleep)
- ☐ Sleep Disturbances (Interrupted Sleep)
- ☐ Vaginal Dryness/Atrophy
- ☐ Harder to Reach Climax
- ☐ Decreased Muscle Size/Strength
- ☐ Increased Facial or Body Hair
- ☐ Sensitivity to Chemicals
- ☐ Caffeine or Nicotine Needs
- ☐ Cold Extremities
- ☐ Sensitivity to Cold
- ☐ Low(cold) body temperature
- ☐ Elevated Triglycerides
- ☐ Swelling of Ankles/Wrists
- ☐ Brittle or Breaking Nails

Women's Hormone Consultation Questionnaire

Please fill out your information

TOWN & COUNTRY
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Patient Medical Information

Please write down any questions you may have about Prescription Bio-Identical Hormone Replacement Therapy (Rx BHRT), other medications, or any other questions that come up as you read through the materials you have received. Bring this question sheet with you to your consultation so you can discuss this information with your pharmacist. Thank you.

COMMUNICATION CONSENT

Would you like to permit anyone to have access to information?

☐ Yes ☐ No

Please list any persons to whom we are permitted to give information to (give name and relationship).

Name and Relationship

Name

Date

Signature