Community Clinical Pharmacy 480-969-0600

Hormone Related Health Questionnaire

Have you ever experienced any of the following symptoms recently? Please circle the number that best describes your experience, ZERO being none, ONE being extremely mild and TEN being extremely severe.

Symptom											
Sleep Disruptions	0	1	2	3	4	5	6	7	8	9	10
Fatigue	0	1	2	3	4	5	6	7	8	9	10
Vaginal Dryness	0	1	2	3	4	5	6	7	8	9	10
Irritability	0	1	2	3	4	5	6	7	8	9	10
Nervousness	0	1	2	3	4	5	6	7	8	9	10
Breast Tenderness	0	1	2	3	4	5	6	7	8	9	10
Hot Flashes	0	1	2	3	4	5	6	7	8	9	10
Dry Skin	0	1	2	3	4	5	6	7	8	9	10
Nails Breaking/peeling	0	1	2	3	4	5	6	7	8	9	10
Mood Swings	0	1	2	3	4	5	6	7	8	9	10
Arthritis	0	1	2	3	4	5	6	7	8	9	10
Loss of Recent Memory	0	1	2	3	4	5	6	7	8	9	10

Weight Gain 0 1 2 3 4 5 6 7 8 9 10

Decreased Sex Drive 0 1 2 3 4 5 6 7 8 9 10

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

Fluid Retention 0 1 2 3 4 5 6 7 8 9 10

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

Night Sweats 0 1 2 3 4 5 6 7 8 9 10

Hair Loss 0 1 2 3 4 5 6 7 8 9 10

Hard to Reach Climax 0 1 2 3 4 5 6 7 8 9 10

Bladder symptoms 0 1 2 3 4 5 6 7 8 9 10

Name___________________________________ Date___________________

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Female Hormone Related Health Questionnaire

Name: ____________________________________Date of Birth:___________Date of Last Menstrual Period:_____

Address: ____City:________________Zip Code:______________

Phone #: Home___________________Cell:____________________ Work______________________

Your e-mail address____

May we use your email address to inform you about our upcoming events___________________________

Allergies (to medicine & food, etc.):____

Ht:____________Wt:_________

Do you smoke?_____________How much alcohol do you drink? None , Little , Moderate , Excessive

How much caffeine do you consume per day?_______________________

Any History of Cancer (Self or Family member): _________Who?______________________________________

If Mother or father deceased, what was the cause of death____

Are you sexually active?_____Is intercourse painful?_____Do you use vaginal lubricants for intercourse?_____

Are you trying to get pregnant?_____Have you been diagnosed with genital herpes?________

Do you have lumpy breasts?_________________ Do you do breast self exam every month?______________

How many times a week do you exercise?_________________________________

Name & Phone # of Your Doctor:____

List of Current Medication:____

How much Calcium do you take a day?__________________

List of Medical Conditions:____

List past Hormone Replacement Therapies____

Have you had a Hysterectomy? Yes No , Partial Complete, When?________ Reason________________

Any other surgeries____

Date of Last Papsmear_____________Were the results normal?________Date of last mammo______Normal___

Date of last Bone Density Test________________________Were the results normal?_______________________

Occupation: ____

Marital Status: S_____M______D_______W________ # of Pregnancies?__________Children? _____________

Who referred you to us?____

What are your Chief complaints today?____

Pharmacist's Recommendation:

____

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Pharmacists may not prescribe medications. The recommendations made by the pharmacist must be approved by patient's prescriber. By signing below, I hereby acknowledge that the risks and benefits of hormone replacement therapy have been explained to me and that my questions have been answered.

Patient's signature___________________________________ Date_________________