



Stanley Pharmacy Compounding Center
2413 West Beebe-Capps Expressway
Searcy, Arkansas 72143

Tel. (501) 305-4108

Fax (501) 305-4514

CONFIDENTIAL HORMONE EVALUATION--Female

I understand that the fee for this consultation is \$60.00. _____(initials)

I understand that hormone replacement is not a form of birth control & I must use other methods to prevent pregnancy. _____(initials)

I understand that insurance does not always cover compounded hormone replacement prescriptions, but Stanley Pharmacy will provide claim forms to turn in to request reimbursement. _____(initials)

I acknowledge my understanding of the Health Insurance Portability and Accountability Act (HIPAA) and that I have been offered a copy of Stanley Pharmacy's Notice of Privacy Practices.

Signature _____ Initials _____

Who referred you to Stanley Pharmacy for hormone replacement?

Today's Date: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Best Number to reach you _____

Place of Employment _____ Height: _____ Weight: _____

Email Address _____

Insurance Information

Insurance Name: _____

Subscriber I. D. #: _____ Group #: _____

Cardholder Name: _____ Cardholder Birthdate _____

Doctor's Name

Address

Phone

Allergies: Please check all that apply.

penicillin morphine dye allergies pet allergies
 codeine aspirin nitrate allergy seasonal (pollen) allergies
 sulfa drugs food allergies no known allergies other: _____

Please describe the allergic reaction you experienced and when it occurred.

		How often & how much?
Do you use tobacco?	Yes/No	_____
Do you use alcohol?	Yes/No	_____
Do you use caffeine?	Yes/No	_____

Please list any OTC (Over-the-Counter) products that you use occasionally or regularly.
(i.e. pain relievers, sleep aids, vitamins, antacids, allergy medications, laxatives, or herbal supplements)

Please list all current medical conditions/diseases.

(i.e. high blood pressure, high cholesterol, diabetes, thyroid disease, migraines, depression, arthritis, asthma)

Current Prescription Medications:

Medication Name	Strength	Date Started	How often per day
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What Pharmacy do you currently use? _____

List Hormones previously taken	Date started	Date stopped	Reason
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever used oral contraceptives? _____

If yes, which one(s)? _____

Any problems? If so, please describe. _____

Gynecological History

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

Any interrupted pregnancies? _____

Have you had a hysterectomy? _____ If yes, when? _____

Have you had your ovaries removed? _____ If yes, when? _____

Have you had a tubal ligation? _____ If yes, when? _____

When was your last mammogram? _____

When was your last PAP Smear? _____

Since your first began having periods, have you ever had what you would consider to be abnormal cycles? _____ If so, when? _____ Please describe: _____

When was your last period? _____ How long did it last? _____

Do you have or have you ever had Premenstrual Syndrome (PMS)? _____

If yes, please describe _____

Are you sexually active? _____

If yes, what form of contraception do you use? _____

Do you have a family history of any of the following?

Uterine Cancer	_____	Family member(s)	_____
Ovarian Cancer	_____	Family member(s)	_____
Fibrocystic Breast	_____	Family member(s)	_____
Breast Cancer	_____	Family member(s)	_____
Heart Disease	_____	Family member(s)	_____
Osteoporosis	_____	Family member(s)	_____

What is your major complaint? _____

What has changed to make you feel less like yourself? _____

What symptom do you hope we can most help you with? _____

Have you experienced any of the following symptoms recently? Please circle the number that best describes your experiences, with **one** being **extremely mild** and **ten** being **extremely severe**.

Sleep disruptions/Insomnia	1	2	3	4	5	6	7	8	9	10
Fatigue	1	2	3	4	5	6	7	8	9	10
Mood Swings	1	2	3	4	5	6	7	8	9	10
Irritability	1	2	3	4	5	6	7	8	9	10
Nervousness	1	2	3	4	5	6	7	8	9	10
Depression	1	2	3	4	5	6	7	8	9	10
Weight Gain	1	2	3	4	5	6	7	8	9	10
Headaches	1	2	3	4	5	6	7	8	9	10
Loss of Recent Memory	1	2	3	4	5	6	7	8	9	10
Fluid Retention	1	2	3	4	5	6	7	8	9	10
Arthritis	1	2	3	4	5	6	7	8	9	10
Decreased Sex Drive	1	2	3	4	5	6	7	8	9	10
Harder to Reach Climax	1	2	3	4	5	6	7	8	9	10
Vaginal Dryness	1	2	3	4	5	6	7	8	9	10
Dry Skin/Hair	1	2	3	4	5	6	7	8	9	10
Hair Loss	1	2	3	4	5	6	7	8	9	10
Fibrocystic Breast	1	2	3	4	5	6	7	8	9	10
Breast Tenderness	1	2	3	4	5	6	7	8	9	10
Night Sweats	1	2	3	4	5	6	7	8	9	10
Hot Flashes	1	2	3	4	5	6	7	8	9	10
Bladder Symptoms	1	2	3	4	5	6	7	8	9	10
Heavy/Irregular Menses	1	2	3	4	5	6	7	8	9	10
Cramps	1	2	3	4	5	6	7	8	9	10
Breakthrough Bleeding	1	2	3	4	5	6	7	8	9	10

Follow-Up Checklist

