706 W. Montecito Ave. Phoenix, AZ 85013
Phone: (602) 277-4714 Fax: (602) 264-1469

PATIENT INFORMATION AND HEALTH SUMMARY

Please complete the following confidential information and return it to your pharmacist

NAME_____/_____/_____
Last First M.I.

ADDRESS_____/_____/_____/_____
Street City State Zip Code

PHONE (_____)_____ SEX ☐ Male ☐ Female ☐ Other

Date of Birth _____/_____/_____ Height _____ Weight _____
Month Day Year

Email Address_____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much and how often?_____

Do you smoke? ☐ Yes ☐ No If yes, how many packs per day?_____

Do you exercise? ☐ Yes ☐ No If yes, what type and how often?_____

Do you consume caffeine? ☐ Yes ☐ No If yes, what type and how often?_____

Please describe your diet:_____

_____

Are you currently on any prescription or non-prescription medications/supplements? ☐ Yes ☐ No

If yes, please list the medications and/or supplements on the lines below:

Medications	Supplements
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____

MEDICATION ALLERGIES (please check all that apply):

☐ None known ☐ Penicillin ☐ Aspirin ☐ Sulfa ☐ Codeine

If allergic to any of the above medications, please describe what happens:_____

Please list any other medication and/or food allergies you have:_____

_____

Are you chemically and/or environmentally sensitive? ☐ Yes ☐ No

Do you want child-resistant tops on your prescription containers? ☐ Yes ☐ No

Do you have insurance that pays for your prescriptions? ☐ Yes ☐ No

Who referred you to us?_____

Please list your health care providers and the date of your last visit:

Name:_____	Name:_____
Specialty:_____	Specialty:_____
Date of Last Visit:_____	Date of Last Visit:_____

PATIENT SIGNATURE_____ DATE_____/_____/_____

Natural Hormone Replacement Therapy Consultation/Assessment Information

MEDICAL HISTORY

Your Past/Current Medical Conditions (please check all that apply)	
☐ Asthma ☐ Cancer (type:_____) ☐ Chronic Fatigue Syndrome ☐ Depression ☐ Diabetes (type:_____) ☐ Epilepsy ☐ Fractures ☐ Headaches/Migraines ☐ Heart Condition (type:_____) ☐ High Blood Pressure ☐ Liver Disorder ☐ Osteoporosis/Osteopenia	☐ Arthritis ☐ Blood Clots (DVT, pulmonary embolism) ☐ Clotting Disorder ☐ Eating Disorder ☐ Fibromyalgia ☐ Gallbladder Disease ☐ High Cholesterol ☐ Kidney Disorder ☐ Thyroid Disorder ☐ Ulcers ☐ Vericose Veins ☐ Other:_____
Family History (please check all that apply)	
☐ Cancer: type-_____ who?_____ ☐ Diabetes: type-_____ who?_____	☐ Heart Disease: who?_____ ☐ Alzheimer's Disease: who?_____ ☐ Osteoporosis: who?_____

MENSTRUAL HISTORY

1. **PMS, or premenstrual syndrome, is defined as a condition in which a variety of symptoms may occur during the 7 to 14 days before a menstrual period begins. Please check any symptoms you currently experience or have experienced in the past from the list below:**

☐ Mild physiological discomfort	☐ Bloating	☐ Weight gain
☐ Swelling of hands and feet	☐ Breast tenderness	☐ Aches and pains
☐ Poor concentration	☐ Sleep disturbances	☐ Change in appetite

How would you describe your PMS in the past?

☐ Didn't Notice ☐ Sometimes ☐ Each Time ☐ Severe

Do you currently suffer from PMS? ☐ Yes ☐ No **If yes, what time of month?**_____

As you have aged, has your PMS worsened? ☐ Yes ☐ No

Please describe what you have noticed triggers your PMS:_____

_____

2. **Describe your menstrual periods presently (check all that apply):**

☐ Regular	☐ Light	☐ Sporadic	☐ Brown Blood
☐ Irregular	☐ Heavy	☐ No Periods	☐ Bright Red Blood
☐ Clotty	☐ Premenstrual Spotting (≥3 days)		☐ Postmenstrual Spotting (≥3 days)

3. **Have you ever had cramping or pain with your period?** ☐ **Yes** ☐ **No**

4. **Have you ever skipped periods all together?** ☐ **Yes** ☐ **No**

5. **When was your last menstrual period?**_____**How long is your cycle?**_____**days**

6. **Do you have any bleeding between periods?** ☐ **Yes** ☐ **No** **When?**_____

7. **When was your last test:**

- **Pap smear** _____
- **Bone Density** _____
- **Cholesterol** _____
- **Hormone Panel** _____
- **Mammogram** _____
- **Thyroid Panel** _____

8. **Have you ever taken hormones (synthetic or natural) before?** ☐ **Yes** ☐ **No**
   If yes, please list the hormone medication(s) you have used on the lines below:

	Drug Name	Strength	When Used	Side Effects	Benefits
1					
2					
3					
4					
5					

9. **If you discontinued the use of hormones, please briefly explain why. Additionally, please explain why you are seeking bio-identical hormone replacement therapy (HRT).**

_____

_____

10. **Have you tried any alternative therapies or taken any herbal or homeopathic products?**
    ☐ **Yes** ☐ **No** **If yes, please list them here:** _____

_____

OBSTETRICAL HISTORY

1. **Are you sexually active? ☐ Yes ☐ No If yes, please check how frequently you have sex below:**
   ☐ Rarely ☐ Sometimes ☐ Often
   Are you satisfied with this level of sexual activity? ☐ Yes ☐ No
2. **Are you trying to get pregnant? ☐ Yes ☐ No**
3. **Current method of birth control?_____ How long?_____**
4. **Past birth control and any related problems?_____**
5. **Have you ever had children? ☐ Yes ☐ No**
6. **Number of: pregnancies_____ deliveries_____ miscarriages_____**

GYNECOLOGICAL HISTORY

1. **Have you had a hysterectomy? ☐ Yes ☐ No If yes, when?_____**
2. **Have you had any part of or your whole ovary removed? ☐ Yes ☐ No If yes, when?_____**
3. **Have you ever had a tubal ligation? ☐ Yes ☐ No If yes, when?_____**
4. **Have you ever had an abnormal pap? ☐ Yes ☐ No**
   If yes, what was the abnormality and how was it treated?_____
   _____
5. **Please check any of the following conditions you have had in the past or currently have:**

☐ HSV (vaginal herpes)	**☐ Cervical cancer**	**☐ Uterine fibroids**
☐ HPV (vaginal warts)	**☐ Cervical dysplasia**	**☐ Breast fibroids**
☐ Ovarian cysts	**☐ Pelvic infections**	**☐ Infertility**

☐ Increased facial and/or body hair growth

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Release Authorization

_____ I hereby release my Physician to furnish an agent of Melrose Pharmacy any and all records pertaining to my medical history, services rendered, and/or treatments.

_____ I authorize my Pharmacist to release my personal medication and/or other medical information to my Physician(s) upon request or as deemed necessary.

_____ I understand that employees of Melrose Pharmacy will protect my privacy and this information will be released to other healthcare professionals only when necessary in order to provide health care services to me. This authority shall continue until revoked by me in writing.

Physician Name:_____

Physician Name:_____

Physician Name:_____

Patient Name:_____

Address:_____

City, State, Zip:_____

Phone:_____

Signature:_____ Date:_____