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

What Pharmacy do you currently use?_____

List Hormones previously taken	Date started	Date stopped	Reason

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?_____
_____
_____
__

HORMONE REPLACEMENT THERAPY PATIENT INFORMATION SHEET

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

_____ Gift bag & Welcome Letter
_____ Thank You Card
_____ 3 Week phone call
_____ 3 Month phone call
_____ 1 Year Appointment Scheduled
_____ 1 Year Appointment

Consultation/Visit Notes