*Serving the community for good health*

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## Riley's Drugs Confidential Female Hormone Evaluation
## Follow-Up

Name: ______________________________ Birth date: __________ Age: ______
Address: ____________________________________________________________________
City: ______________________________ State: _________ Zip: _____________
Phone: ____________________________ Email Address: ______________________
Cell Phone: _________________________ Height: __________ Weight: ________
Primary Care MD: ____________________ Your Ob/Gyn________________________
Address: ___________________________ Address: __________________________
Phone Number: ______________________ Phone Number: _____________________
Fax Number: ________________________ Fax Number: _______________________

**At this point in the program my primary goals and/or chief concerns are:**

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

**I complied with the plan designed for me at the last visit and take my supplements and prescriptions as scheduled:** □ Everyday □ 75% of the time □ 50% of the time □ 25% of the time □ Rarely
List any challenges/obstacles:______________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

**Over-the-counter (OTC):** Please list the products you use occasionally or regularly including pain relievers, sleep aids, antacids, antihistamines, cold medicine, laxatives/stool softeners, diet aids, ect.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

**Nutritional/Natural Supplements:** Please list the products you are using, including vitamins, minerals, herbs, enzymes and nutrition/protein supplements.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

**Current Prescription Medications:** Strength Date Started How often per day.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Patient Name: ______________________________ Today's Date:______________

**Symptoms:**

List any new symptoms:_______________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

Rate each symptom by checking the appropriate modifier. This section is repeated upon subsequent visits to monitor progress.

| | **Absent** | **Mild** | **Moderate** | **Severe** | **Comments:** |
|---|---|---|---|---|---|
| Fibrocystic Breast | ☐ | ☐ | ☐ | ☐ | ______________________ |
| Weight Gain | ☐ | ☐ | ☐ | ☐ | ______________________ |
| Heavy/Irregular Menses | ☐ | ☐ | ☐ | ☐ | ______________________ |
| Hot Flashes | ☐ | ☐ | ☐ | ☐ | ______________________ |
| Dry Skin/Hair | ☐ | ☐ | ☐ | ☐ | ______________________ |
| Anxiety | ☐ | ☐ | ☐ | ☐ | ______________________ |
| Depression | ☐ | ☐ | ☐ | ☐ | ______________________ |
| Night Sweats | ☐ | ☐ | ☐ | ☐ | ______________________ |
| Vaginal Dryness | ☐ | ☐ | ☐ | ☐ | ______________________ |
| Headaches | ☐ | ☐ | ☐ | ☐ | ______________________ |
| Irritability | ☐ | ☐ | ☐ | ☐ | ______________________ |
| Mood Swings | ☐ | ☐ | ☐ | ☐ | ______________________ |
| Breast Tenderness | ☐ | ☐ | ☐ | ☐ | ______________________ |
| Sleep Disturbances/Insomnia | ☐ | ☐ | ☐ | ☐ | ______________________ |
| Cramps | ☐ | ☐ | ☐ | ☐ | ______________________ |
| Fluid Retention | ☐ | ☐ | ☐ | ☐ | ______________________ |
| Breakthrough Bleeding | ☐ | ☐ | ☐ | ☐ | ______________________ |
| Fatigue | ☐ | ☐ | ☐ | ☐ | ______________________ |
| Loss of Memory | ☐ | ☐ | ☐ | ☐ | ______________________ |
| Bladder Symptoms | ☐ | ☐ | ☐ | ☐ | ______________________ |
| Arthritis | ☐ | ☐ | ☐ | ☐ | ______________________ |
| Harder to Reach Climax | ☐ | ☐ | ☐ | ☐ | ______________________ |
| Decreased Sex Drive | ☐ | ☐ | ☐ | ☐ | ______________________ |
| Hair Loss | ☐ | ☐ | ☐ | ☐ | ______________________ |

**Please write down any Questions you have at this point in the therapy.**

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

If you would like us to share this information with your physician, please initial: __________

Signature: ___________________________________ Date: ________________________________

Your signature acknowledges your understanding of Riley's Drugs Notice of Privacy Practices according to HIPPA regulations. It does not acknowledge your agreement of any restrictions you may have requested regarding your Protected Health Information.

Patient Name: ____________________________________ Today's Date:________________