RILEY'S DRUGS & VITAL CARE
SINCE 1924
Serving the community for good health

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Riley's Drugs Confidential Female Hormone Evaluation
Medical History

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: _____

Allergies: Please check all that apply.
□ No Known Allergies
□ Penicillin □ Morphine □ Dye allergies □ Pet allergies
□ Codeine □ Aspirin □ Nitrate Allergy □ Seasonal (pollen) allergies
□ Sulfa drug □ Food allergies Other: _____
Please describe the allergic reaction you experienced and when it occurred?

_____
_____

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.

_____
_____
_____

Medical Conditions/Diseases: Please check all that apply to you.
□ Heart disease (example: Congestive Heart Failure)
□ High Cholesterol or lipids (example: Hyperlipidemia)
□ High Blood Pressure (example: Hypertension)
□ Cancer
□ Ulcers (stomach, esophagus)
□ Thyroid disease
□ Hormonal Related Issues
□ Lung condition (example: asthma, emphysema, COPD)
□ Blood Clotting Problems
□ Diabetes
□ Arthritis or joint problems
□ Depression
□ Epilepsy
□ Headaches/migraines
□ Eye Disease (glaucoma, ect.)
□ Other: Please List: _____

_____
_____

Patient Name: _____ Today's Date:_____

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

_____
_____
_____
_____
_____
_____

List Hormones previously taken. Date Started Date Stopped Reason

_____
_____
_____
_____

Bone Size: □ Small □ Medium □ Large **Body Type**: □ Androgenic □ Estrogenic

Have you ever used oral contraceptives? □ No □ Yes

Any Problems? □ No □ Yes

If YES, describe any problem(s). _____

_____

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

Any interrupted pregnancies? □ No □ Yes

Have you had a hysterectomy? □ No □ Yes (Date of Surgery) _____

Ovaries removed? □ No □ Yes

Have you had a tubal ligation? □ No □ Yes

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

Uterine Cancer	□ No	□ Yes	Family member(s) _____
Ovarian Cancer	□ No	□ Yes	Family member(s) _____
Fibrocystic breast	□ No	□ Yes	Family member(s) _____
Breast Cancer	□ No	□ Yes	Family member(s) _____
Heart Disease	□ No	□ Yes	Family member(s) _____
Osteoporosis	□ No	□ Yes	Family member(s) _____
Diabetes	□ No	□ Yes	Family member(s) _____

Have you had any of the following tests performed? Check those that apply and note the date of last test.

Mammography	□ No	□ Yes	Date: _____
PAP Smear	□ No	□ Yes	Date: _____
Lab Work	□ No	□ Yes	Date: _____
Thyroid Panel	□ No	□ Yes	Date: _____

Since you began having periods, have you ever had what you would consider to be abnormal cycles?

If Yes, please explain (such as age when this occurred, symptoms ect): □ No □ Yes Date: _____

_____
_____
_____

When was your last period? _____

How many days did it last? _____

Do you have, or did you ever have Premenstrual Syndrome (PMS)? □ No □ Yes

If YES, explain symptoms:_____

_____
_____

Patient Name: _____ Today's Date:_____

Habits:

My appetite is: □ Poor □ Fair □ Good □ Very Good □ Out of Control

My daily diet usually includes: list your typical meals

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Dietary Restictions:_____

Do you need help with your diet? □ No □ Yes

Do you get at least 20 minutes of relaxation each day? □ No □ Yes

Do you get a restful night sleep? □ No □ Yes

How much water do you drink daily? _____

How often and how much?

Do you use tobacco? □ No □ Yes _____

Do you use alcohol? □ No □ Yes _____

Do you use caffeine? □ No □ Yes _____

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	□	□	□	□	_____

Patient Name: _____ Today's Date:_____

How did you arrive at the decision to consider Bio-Identical Hormone Replacement Therapy?

Doctor □ Self □ Friend/Family Member □ Other □ _____

What are your Goals with taking BHRT?

_____
_____
_____
_____

Please write down any Questions you have about Bio-Identical Hormone Replacement 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:_____