



WILSON PHARMACY

www.wilsonpharmacy.com

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Hormone Replacement Therapy Consultation Form

Date: _____

Name: _____ DOB: _____ Height: _____ Weight _____

Street Address: _____ City: _____ State: _____
Zip/Postal Code: _____

Primary Care Physician: _____ OB/GYN: _____
Is either physician aware of your interest in BHRT? _____

Email: _____ Home Phone: _____

Work Phone: _____ Occupation: _____
How did you hear about Wilson Pharmacy's Hormone program? _____

What is your greatest need or problem? (List the most important, then list other issues in order of importance) _____

Your current medical conditions or diagnoses: _____

Drug Allergies: _____

Allergies to food, pollen, environment etc: _____

Names of ALL prescription medications, taken in last 6 months. Include strength and how you take them: _____

Indicate any herbal products you have taken: _____

Names of ALL Vitamins, Supplements, Non-Prescription medicines or other OTC products that you are currently using: _____

If you are currently taking medication for a thyroid condition, which one and dose?

Have you ever had a bone density scan? YES NO

If yes, When? _____ Results _____

Do you use tobacco products? YES NO

If yes, What? _____ How Much? _____ How Long? _____

Do you use alcohol products? YES NO

What? _____ How Much? _____ How Long? _____

Do you use caffeine products? YES NO

What? _____ How Much? _____

How much water do you drink in one day (24 hour)? _____ oz. _____ glasses.

Do you have any dietary restrictions (such as salt, carbohydrates, milk products, red meat, etc.) _____

When was your last: General medical exam _____ Pelvic exam _____

Have you ever had an abnormal pap? YES NO When? _____

At what age was your first period? _____

When was your most recent or last period? _____

Do you still have your period? YES NO

If yes, how many days from the start of one period to the start of the next? _____ days

Number of days of flow: _____

Amount of bleeding _____

Describe any cramping or pain you may have? _____

Do you have pain at any other time in your cycle? YES NO

Any current changes in your normal cycle? _____

Any bleeding between periods? _____

When? _____ Describe: _____

What were your periods like as a teenager? _____

If you have ever had Premenstrual Symptoms (PMS), please describe: _____

How long have you had PMS symptoms? _____

Starting and ending when: _____

If your periods have ever been difficult, irregular, or abnormal in any way, please describe: _____

If you are currently having any pelvic pain, pressure, or fullness, describe: _____

Describe any vaginal discharge or itching: _____
Treatment of any of the above: _____

Have you ever had any of the following surgeries:

Tubes Tied (tubal ligation)? YES NO When? _____ At what age? _____

Uterus removed (hysterectomy)? YES NO When? _____ At what age? _____

Ovaries removed (oophorectomy)? YES NO When? _____ At what age? _____

Were there any problems associated with the surgery or removal of any of these organs?

Has your doctor diagnosed menopause, or told you that you are in menopause?

YES NO If yes, at what age? _____

If at age 40 years or earlier, was Premature Ovarian Failure, diagnosed? YES NO

Have you ever been pregnant? YES NO

Are you trying to get pregnant? YES NO

What was the age at your first pregnancy? _____

How many times have you been pregnant? _____

How many resulted in the birth of living children? _____

Were there any problems? _____

Any interrupted pregnancies (miscarriages or abortions)? YES NO

Current birth control method: _____

How long? _____ Any problems? _____

Have you ever used any of the following birth control methods:

Oral Contraceptives (Birth Control Pills): YES NO

Total months/years used: _____

Any side effects to Birth Control Pills: _____

Intra-Uterine Device (IUD) YES NO Problems _____

When was your last mammogram? _____ Results _____

Do you examine your breast monthly? YES NO

Have you ever experience breast pain, discomfort, nipple discharge, or swelling other than when pregnant? Give details: _____

Have you ever been diagnosed with lumps, fibroids, breast cancer, or similar breast conditions? _____

If your doctor has recently ordered lab tests or diagnostic procedures for you, please give details, including whether the test or procedure was performed, and the results: _____

CHECK A BOX FOR EACH SYMPTOM which best describes how you have been feeling for the past months. *This only needs to be filled out if you are not interested in saliva testing. This questionnaire will help us to recommend a customized hormone plan to submit to your physician.*

- 0= None (symptom not present)
 1= Mild (present but not distressing)
 2= Moderate (distressing, but not interfering with daily life)
 3= Severe (very distressing, interferes with daily life)

Hot Flashes	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Night Sweats	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Light-headed feelings/dizziness	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Headaches	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Sleep disorders/Sleeplessness	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Unusual tiredness/Fatigue	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Irritability	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Depression	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Anxiety/Tension/Nervousness	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Mood swings/Mood changes	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Confusion/Difficulty concentrating	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Forgetfulness/Short-term memory loss	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Angry outbursts/Arguments/ Violent tendencies	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Crying easily	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
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Backache	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Joint pains	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Muscle pains	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Muscle cramps/spasms	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Problems with wound healing time	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Acne/pimples/Skin flushing	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Dry skin/Dry hair	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Crawling feeling under skin	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
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Frequency Urinary Tract Infection (UTI)	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Urinary frequency	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Vaginal dryness	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Abnormal bleeding	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Pelvic pain, pressure, fullness, or bloating	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Uncomfortable intercourse	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Loss of sexual feeling/desire	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Loss of arousability and capacity for orgasm	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Loss of sexual sensitivity	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Loss of vitality	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Nipple sensitivity	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Discharge or leaking from nipples	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Breast tenderness	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Loss of pubic hair	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Swelling of hands, ankles, or breasts	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
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Heart palpitations	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Shortness of breath	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Food/sweets/salt cravings	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Increased appetite/weight gain	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3