



Tracy Dryer, RPh  
19321 E. US 40 Hwy, Suite P  
Independence, MO 64055  
816-795-6034  
Fax: 816-795-1286  
Sterlingrx.net

### Female Information and Health Summary

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City/State/ZIP \_\_\_\_\_

Home Phone (\_\_\_\_)-\_\_\_\_-\_\_\_\_ Cell (\_\_\_\_)-\_\_\_\_-\_\_\_\_ Fax (\_\_\_\_)-\_\_\_\_-\_\_\_\_

Email address \_\_\_\_\_ Who referred you to us? \_\_\_\_\_

Please List Your Healthcare Providers & Indicate Which Doctor to Contact Regarding Hormone Therapy

Name \_\_\_\_\_

Name \_\_\_\_\_

Specialty \_\_\_\_\_

Specialty \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

Fax \_\_\_\_\_

Insurance Information:

Plan Name \_\_\_\_\_ BIN# \_\_\_\_\_ PCN# \_\_\_\_\_

ID# \_\_\_\_\_ Pharmacy Group# \_\_\_\_\_

Who is the main cardholder? \_\_\_\_\_ Your member # \_\_\_\_\_

Any Known Medication Allergies? \_\_\_\_\_

Please List Any Medications You Are **Currently** Taking, Including Vitamins, Natural Supplements, or Non-Prescription Medications:

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Is your **Diet**: 1 Bad 2 Fair 3 Good 4 Very Good (please circle)

**Exercise:** type of activity, how frequent, and for how long? \_\_\_\_\_  
\_\_\_\_\_

**Employer and Job Title** \_\_\_\_\_

Circle your perceived stress level: 1 None 2 Mild 3 Moderate 4 Severe 5 Extremely Severe

## Family History

Please check all that apply:

<input type="checkbox"/> Cancer (type)		
<input type="checkbox"/> Breast _____	Relationship to you _____	
<input type="checkbox"/> Uterine _____	Relationship to you _____	
<input type="checkbox"/> Ovarian _____	Relationship to you _____	
<input type="checkbox"/> Other _____	Relationship to you _____	
<input type="checkbox"/> Diabetes; type _____	Relationship to you _____	
<input type="checkbox"/> Heart Disease _____	Relationship to you _____	
<input type="checkbox"/> Osteoporosis _____	Relationship to you _____	
<input type="checkbox"/> Alzheimer's Disease _____	Relationship to you _____	
<input type="checkbox"/> Thyroid Disease _____	Relationship to you _____	

## Past or Present Medical Conditions

Please check all that apply:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Fractures _____
<input type="checkbox"/> Cancer (type: _____)	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Depression	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Liver Disorder
<input type="checkbox"/> Diabetes (type: _____)	<input type="checkbox"/> Kidney Disorder	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Heart Condition _____	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Chronic Fatigue Syndrome
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Clotting Disorder	<input type="checkbox"/> Other _____
<input type="checkbox"/> Osteoporosis/Osteopenia	<input type="checkbox"/> Gallbladder Disease	

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## Gynecological History

- Have you had a hysterectomy?  Yes  No  
If Yes, when? \_\_\_\_\_
- Have your ovaries been removed?  Yes  No  
If Yes, when? \_\_\_\_\_
- Have you ever had a tubal ligation?  Yes  No  
If Yes, when? \_\_\_\_\_
- Have you ever had an abnormal pap?  Yes  No  
If Yes, when? \_\_\_\_\_
- Do you perform self-breast exams?  Yes  No  
How often? \_\_\_\_\_

## Obstetrical History

- Are you sexually active?  Yes  No
- Are you trying to get pregnant?  Yes  No
- Current method of birth control? \_\_\_\_\_ How long? \_\_\_\_\_
- Past method of birth control &/or any problems? \_\_\_\_\_
- Have you ever had children?  Yes  No
- Number of Pregnancies \_\_\_\_\_ Deliveries \_\_\_\_\_ Multiple Births \_\_\_\_\_

**Have you ever had . . . (check all that apply)**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Sexual Problems                        | <input type="checkbox"/> Cervical Cancer      | <input type="checkbox"/> Lack of Sex Drive         |
| <input type="checkbox"/> Cervical Dysplasia                     | <input type="checkbox"/> Painful Intercourse  | <input type="checkbox"/> Ovarian Cysts             |
| <input type="checkbox"/> Vaginal Dryness                        | <input type="checkbox"/> Uterine fibroids     | <input type="checkbox"/> Breast fibroids           |
| <input type="checkbox"/> Vaginal Infections                     | <input type="checkbox"/> Lack of Energy       | <input type="checkbox"/> HPV(vaginal warts)        |
| <input type="checkbox"/> Pelvic Infections                      | <input type="checkbox"/> HSV (vaginal herpes) | <input type="checkbox"/> Inability to reach climax |
| <input type="checkbox"/> Increased facial &/or body hair growth |   |  |

**Menstrual History**

Present state of Menstruation

- |                                  |                                    |                                     |
|----------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Regular | <input type="checkbox"/> Irregular | <input type="checkbox"/> Sporadic   |
| <input type="checkbox"/> Light   | <input type="checkbox"/> Heavy     | <input type="checkbox"/> No Periods |

Have you missed periods altogether?  Yes  No

When was your last period? \_\_\_\_\_ How long is your cycle? \_\_\_\_\_

Do you have bleeding between periods?  Yes  No

Have you ever taken hormones before?  Yes  No

\*\*If so, please list **previous and current** hormones taken, doses, and any side effects here:

\_\_\_\_\_

Have you tried alternative therapies or taken any herbal or homeopathic products?

\_\_\_\_\_

How did you become interested in bio-identical hormones?

\_\_\_\_\_

**Please check ALL symptoms below that apply (this is very important to the evaluation process)**

**Symptoms of low Progesterone?**

- Swollen Breasts
- Anxiety/Irritability
- Irregular menses
- Infertility
- Weight Gain
- Mood Swings
- PMS
- Joint Pain
- Food Cravings
- Headaches \_\_\_\_\_per week
- Cramping
- Acne
- Low Sex Drive
- Depression
- Fuzzy Thinking
- Low Energy

**Symptoms of low Estrogen?**

- Hot Flashes
- Dry Skin
- Foggy Thinking
- Painful Intercourse
- Night Sweats
- Yeast Infections
- Bone Loss
- Insomnia
- \_\_\_\_\_per week
- Heart Palpitations
- Low Sex Drive
- Vaginal Dryness/Atrophy
- Memory Lapses
- Depression
- Headaches \_\_\_\_\_per week

**Symptoms of low Testosterone?**

- Depression
- Joint Pain
- Heart Palpitations
- Fibromyalgia
- Urinary Incontinence
- Low Sex Drive
- Memory Lapses
- Vaginal Dryness
- Low Energy
- Bone Loss
- Muscle Weakness
- Thinning Skin/Scalp Hair

Other Symptoms \_\_\_\_\_

**Top 3 symptoms you'd like resolved** \_\_\_\_\_

**Circle the number that best describes the DEGREE of symptom intensity you have experienced over the past month(s)**

	<b>None 0</b>	<b>Mild 1</b>	<b>Moderate 2</b>	<b>Severe 3</b>
1. Hot flashes, perspiration, and/or chilly sensations?	0	1	2	3
2. Insomnia or restless, fragmented sleep?	0	1	2	3
3. Irritability, feeling anxious or apprehensive?	0	1	2	3
4. Feeling of depression and unhappiness and/or being miserable without obvious reason?	0	1	2	3
5. Sensations of dizziness or swimming in the head?	0	1	2	3
6. Feeling of weariness of mind and body with desire for rest; disinclination to make further efforts?	0	1	2	3
7. Pain of any kind affecting joints or muscles?	0	1	2	3
8. Headaches of any kind (tension, migraine, etc)?	0	1	2	3
9. Quickening or acceleration of heartbeat or fluttering/pounding heartbeat in a sitting or resting position?	0	1	2	3
10. Thinning or loss of scalp hair?	0	1	2	3

**Have you ever had . . .**

	<b>Never 0</b>	<b>Infrequently 1</b>	<b>Sometimes 2</b>	<b>Most of Time 3</b>	<b>Always 4</b>
1. Vaginal burning or itching?	0	1	2	3	4
2. Painful urination or increased frequency or urination?	0	1	2	3	4
3. Leaking of urine when coughing, laughing, sneezing, or on hard work?	0	1	2	3	4
4. Leaking of urine when walking, running, climbing steps, or on light work?	0	1	2	3	4
5. Leaking of urine, regardless of activity, even when in a lying position?	0	1	2	3	4