DANIELS DRUG
COMPOUNDING & WELLNESS PHARMACY

PATIENT INFORMATION AND HEALTH SUMMARY

*****Please mark appropriate responses. Date:*** ____________________

Please complete the following confidential information and return it to your pharmacist.

NAME ______________________________/ ______________________/__________
LAST **FIRST** **M.I.**

ADDRESS ___________________________________ / ____________________ / ____________
STREET **CITY** **STATE / ZIP**

PHONE (____) _______ - ______ SEX: MALE FEMALE DOB ________________ AGE________________

Occupation__________________________ **SS#** ______________________________

EASY OFF OR CHILD RESISTANT BOTTLES?

DO YOU SMOKE? Y N If yes, how many packs per day ____________

DO YOU EXERCISE? Y N If yes, what type? _________________ How often? ___________

CAFFEINE CONSUMPTION? Y N Type? (coffee, soda) ___________ How much/day? ____________

HEIGHT __________ WEIGHT ____________ ALCOHOL? Y N How much/wk? ____________

LIST THE ITEMS YOU CONSUMED IN THE LAST 2 DAYS – FOOD & DRINK : ________________________

Breakfast:

Lunch:

Dinner:

Snacks & times:

Drinks:

MEDICATION ALLERGIES? NONE KNOWN PENICILLIN ASPIRIN SULFA CODEINE

If yes to any allergies, what happens? ____

OTHER MEDICATION AND/OR FOOD ALLERGIES: ____

Are you chemically or environmentally sensitive? Y N

Are you on any prescription or non-prescription medications or supplements? Y N Please list below:

Whom may we thank for referring you to us? ____

Please list your health care practitioners and the dates of your last visit:

Name: ______________________________________ Name: ____

Specialty: ___________________________________ Specialty: _____________________________________

Date of Last Visit: ___________________________ Date of Last Visit: _______________________________

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Continued... Patient information and Health Summary

Past medical conditions (Please check all that apply)

☐ **Asthma**	☐ **Fibromyalgia**
☐ **Cancer (type:_____________)**	☐ **Arthritis**
☐ **Depression**	☐ **Vericose Veins**
☐ **Diabetes (type:____________)**	☐ **Kidney Disorder**
☐ **Headaches/Migraine**	☐ **Thyroid disorder**
☐ **Heart Condition**	☐ **High Cholesterol**
☐ **High Blood Pressure**	☐ **Clotting Disorder**
☐ **Osteoporosis/Osteopenia**	☐ **Gallbladder Disease**
☐ **Fractures**	☐ **Eating Disorder**
☐ **Epilepsy**	☐ **Ulcers**
☐ **Liver Disorder**	☐ **Other:_______________**
☐ **Chronic Fatigue Syndrome**	

Family History
(Please check all that apply)

☐ Cancer (type:__________) ☐ Diabetes (type:_________) ☐ Osteoporosis
☐ Heart disease ☐ Alzheimer's Disease

Obstetrical History

- **Are you sexually active? ☐ Y ☐ N**
- **Are you trying to get pregnant? ☐ Y ☐ N**
- **Current method of birth control?______________ How long?______________________**
- **Past birth control and any related problems?_____________________________________**
- **Have you ever had children? ☐ Y ☐ N Number of pregnancies:_____ Deliveries_____**

Gynecological History

- **Have you had a hysterectomy? ☐ Y ☐ N If yes, when?___________________________**
- **Have you had any part or whole ovary removed? ☐ Y ☐ N If yes, when?_____________**
- **Have you ever had a tubal ligation? ☐ Y ☐ N If yes, when?________________________**
- **Have you ever had an abnormal pap? ☐ Y ☐ N If yes, how was it treated?____________**
- **Do you perform self-breast exams? ☐ Y ☐ N How often?___________________________**
- **Do you douche? ☐ Y ☐ N How often?____**

Check any of the following problems you may have had:

☐ Sexual problems ☐ Vaginal infections ☐ Cervical dysplasia
☐ Lack of sex drive ☐ Pelvic infections ☐ Ovarian cysts
☐ Painful intercourse ☐ HSV(vaginal herpes) ☐ Uterine fibroids
☐ Vaginal dryness ☐ HPV(vaginal warts) ☐ Breast fibroids
☐ Inability to reach climax ☐ Cervical cancer ☐ Lack of energy

☐ Increased facial and/or body hair growth

MENSTRUAL HISTORY

- As a teenager, were your periods…
  - ☐ regular ☐ irregular
  - ☐ light ☐ heavy
  - ☐ spotty ☐ clots
- P.M.S…
  - ☐ sometimes ☐ each cycle
  - ☐ severe ☐ didn't notice
- Presently…
  - ☐ regular ☐ irregular
  - ☐ light ☐ heavy
  - ☐ sporadic ☐ no periods
- Have you ever had cramping with your periods? ☐ Y ☐ N
- Have you missed periods all together? ☐ Y ☐ N
- When was your last menstrual period?_____________How long is your cyle in days? ________
- Do you have bleeding between periods? ☐ Y ☐ N When?__________________________

When was your last test: If you have copies please bring with you to your consultation

- Pap smear ___________
- Cholesterol___________
- Mammogram_________
- Bone Density____________
- Hormone panel__________
- Thyroid panel____________
- Other __________________

- Have you ever taken hormones (synthetic or natural) before? ☐ Y ☐ N
- If so, please list the medications, doses, and any side effects here:____
____
____
____
____
- Have you tried any alternative therapies or taken any herbal or homeopathic products?
☐ Y ☐ N If so, please list them here:____
____
- Please explain how you became interested in Natural Hormone Replacement Therapy?___________________________
____
____

Are you having any of the following (Please check all that apply)	Are you having any of the following (Please check all that apply)

☐ Headaches	☐ Low Sex Drive	☐ Hot flashes	☐ Night Sweats
☐ Anxiety	☐ Moodiness	☐ Heart Palpitations	☐ Sleep Disorders
☐ Depression	☐ Swollen Breasts	☐ Mood Swings	☐ Headaches
☐ Irritability	☐ Fuzzy Thinking	☐ Depression	☐ Anxiety
☐ Food Cravings	☐ Water Retention	☐ Vaginal Dryness	☐ Dry Hair/Hair Loss
☐ PMS Symptoms	☐ Cramps	☐ Short-term Memory Loss	
☐ Painful Breasts	☐ Weight Gain	☐ Frequent Urinary Tract or Yeast Infections	
☐ Painful Joints	☐ Inability to Concentrate	☐ Dry Skin	☐ Painful Intercourse
☐ Insomnia		☐ Shortness of Breath	

Hormone Replacement Therapy Patient Information Sheet

Name:________________________Date:_____________ Initial, 3 month, 6 month, annual

Have you experienced any of the following symptoms? Please circle the number that best describes your experiences, with one being Extremely Mild and ten being Extremely Severe.

Sleep Disruptions	0	1	2	3	4	5	6	7	8	9	10
Fatigue	0	1	2	3	4	5	6	7	8	9	10
Vaginal Dryness	0	1	2	3	4	5	6	7	8	9	10
Irritability	0	1	2	3	4	5	6	7	8	9	10
Nervousness	0	1	2	3	4	5	6	7	8	9	10
Breast Tenderness	0	1	2	3	4	5	6	7	8	9	10
Hot Flashes	0	1	2	3	4	5	6	7	8	9	10
Dry Skin	0	1	2	3	4	5	6	7	8	9	10
Mood Swings	0	1	2	3	4	5	6	7	8	9	10
Arthritis	0	1	2	3	4	5	6	7	8	9	10
Loss of Recent Memory	0	1	2	3	4	5	6	7	8	9	10
Weight Gain	0	1	2	3	4	5	6	7	8	9	10
Decreased Sex Drive	0	1	2	3	4	5	6	7	8	9	10
Depression	0	1	2	3	4	5	6	7	8	9	10
Fluid Retention	0	1	2	3	4	5	6	7	8	9	10
Headaches	0	1	2	3	4	5	6	7	8	9	10
Night Sweats	0	1	2	3	4	5	6	7	8	9	10
Hair Loss	0	1	2	3	4	5	6	7	8	9	10
Harder to Reach Climax	0	1	2	3	4	5	6	7	8	9	10
Bladder Symptoms	0	1	2	3	4	5	6	7	8	9	10

Difficulty getting up in the morning 0 1 2 3 4 5 6 7 8 9 10

Continuing fatigue not relieved by sleep 0 1 2 3 4 5 6 7 8 9 10

Craving for salt & salty foods 0 1 2 3 4 5 6 7 8 9 10

Light headed when standing up quickly 0 1 2 3 4 5 6 7 8 9 10

Everything seems like a chore- Lethargy (lack of energy) 0 1 2 3 4 5 6 7 8 9 10

Increased effort to do everyday tasks 0 1 2 3 4 5 6 7 8 9 10

Decreased sex drive 0 1 2 3 4 5 6 7 8 9 10

Decreased ability to handle stress 0 1 2 3 4 5 6 7 8 9 10

Increased recovery time from illness/injury/trauma 0 1 2 3 4 5 6 7 8 9 10

Depression 0 1 2 3 4 5 6 7 8 9 10

Loss enjoyment or happiness with life 0 1 2 3 4 5 6 7 8 9 10

Increased PMS or Menopausa 0 1 2 3 4 5 6 7 8 9 10

Symptoms increase if meals are skipped or inadequate 0 1 2 3 4 5 6 7 8 9 10

Drive yourself with coffee, colas or snacks just to keep from collapsing 0 1 2 3 4 5 6 7 8 9 10

Thoughts are less focused & more fuzzy 1 2 3 4 5 6 7 8 9 10

Memory is less accurate 1 2 3 4 5 6 7 8 9 10

Decreased tolerance for others 1 2 3 4 5 6 7 8 9 10

Decreased productivity 1 2 3 4 5 6 7 8 9 10

Don't really wake up until 10am-Then afternoon low between 3-4pm 0 1 2 3 4 5 6 7 8 9 10

Continuing fatigue after evening meal 1 2 3 4 5 6 7 8 9 10

Cold hands/feet or cold intolerance 1 2 3 4 5 6 7 8 9 10

Can't fall to sleep easily-insomnia 1 2 3 4 5 6 7 8 9 10

Nighttime awakenings with difficulty falling back to sleep 0 1 2 3 4 5 6 7 8 9 10

Seasonal allergies 1 2 3 4 5 6 7 8 9 10

Constant stress in life & work 1 2 3 4 5 6 7 8 9 10

Unexplained or frequent headaches 1 2 3 4 5 6 7 8 9 10

Bruise easily 1 2 3 4 5 6 7 8 9 10

Frequent or recurring bronchitis, pneumonia or other respiratory infections 0 1 2 3 4 5 6 7 8 9 10

Coughs/colds that stay around several weeks	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Craving for sweets or carbohydrates	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

My blood pressure typically runs________________

High cholesterol	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
No eyebrows or thinning outer eyebrows	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Hives	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Inability to get pregnant; miscarriages	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Varicose Veins	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Dizziness from fluid on the inner ear	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Low body temperature	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Raised temperature	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Tightness in throat; sore throat	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Headaches and Migraines	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Plantar fasciitis- painful soles of feet	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Constipation	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Muscle cramps & stiffness	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Weight Gain	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Hair loss	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Hoarseness or husky voice	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Top three concerns:

1. ____ Onset:__________________

2.____ Onset:__________________

3.____ Onset:__________________

Pharmacy Record Release Authorization

I, the undersigned patient, authorize my pharmacist to release my personal medication and/or other medical information to the following persons or organizations upon request or as deemed necessary:

Name of family member/person authorizing	Address	Telephone
1)		
2)		
3)		

I understand that the employees of Daniels Compounding Pharmacy will protect my privacy and this information will be released to other health care professionals only when it is necessary in order to provide health care services to me. This authority shall continue until revoked by me in writing.

Patient Name:____

Address:____

City, State, Zip:____

Phone:____

Signature:____

Date:____

Patient Name: ________________________________SS#: ________________________________

Question Documentation Form

Please write down any questions you may have about Natural Hormone Replacement Therapy other medications, or any other questions that come up as you read through the materials you have received. Bring this question sheet with you to your consultation so you can discuss this information with your pharmacist. Thank you.

1.

2.

3.

4

5.

DANIELS DRUG

Compounding & Wellness Pharmacy

Service Fee Schedule

Initial Hormone, Nutritional, and Weight Loss Consults
$60.00/30 min prorated

Guaranteed Results!
Daniels Drug Compounding & Wellness Pharmacy
Your results depend on you!
Given that our recommendations are upheld and consultation appointments are attended, we guarantee RESULTS!