

# DANIELS DRUG

## COMPOUNDING & WELLNESS PHARMACY

### PATIENT INFORMATION AND HEALTH SUMMARY

**\*\*Please mark appropriate responses. *Male Form***

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

NAME \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date \_\_\_\_\_  
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: \_\_\_\_\_

206 W OKLAHOMA • GUTHRIE, OK • 73044

PHONE: (405)282-0661 • FAX: (405)282-0631

WEB: [WWW.ASKAMYRPH.COM](http://WWW.ASKAMYRPH.COM)

E-MAIL: [DANIELSDRUG@GMAIL.COM](mailto:DANIELSDRUG@GMAIL.COM)

Date of Last Visit: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

*Continued... Patient information and Health Summary*

Past medical conditions (Please check all that apply)

<input type="checkbox"/> Asthma <input type="checkbox"/> Cancer (type: _____) <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes (type: _____) <input type="checkbox"/> Headaches/Migraine <input type="checkbox"/> Heart Condition <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Osteoporosis/Osteopenia <input type="checkbox"/> Fractures <input type="checkbox"/> Epilepsy <input type="checkbox"/> Liver Disorder <input type="checkbox"/> Chronic Fatigue Syndrome	<input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Arthritis <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Kidney Disorder <input type="checkbox"/> Thyroid disorder <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Clotting Disorder <input type="checkbox"/> Gallbladder Disease <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Ulcers <input type="checkbox"/> Other: _____
<p>Family History (Please check all that apply)</p> <input type="checkbox"/> Cancer (type: _____) <input type="checkbox"/> Diabetes (type: _____) <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Heart disease <input type="checkbox"/> Alzheimer's Disease	

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

- Bone Density \_\_\_\_\_
- Cholesterol \_\_\_\_\_
- **Thyroid panel** \_\_\_\_\_
- Hormone 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? \_\_\_\_\_

\_\_\_\_\_

<p>Are you having any of the following (Please check all that apply)</p> <input type="checkbox"/> Headaches <input type="checkbox"/> Low Sex Drive <input type="checkbox"/> Anxiety <input type="checkbox"/> Moodiness <input type="checkbox"/> Depression <input type="checkbox"/> Swollen Breasts <input type="checkbox"/> Irritability <input type="checkbox"/> Fuzzy Thinking <input type="checkbox"/> Food Cravings <input type="checkbox"/> Water Retention <input type="checkbox"/> Painful Breasts <input type="checkbox"/> Weight Gain	<p>Are you having any of the following (Please check all that apply)</p> <input type="checkbox"/> Hot flashes <input type="checkbox"/> Night Sweats <input type="checkbox"/> Heart Palpitations <input type="checkbox"/> Sleep Disorders <input type="checkbox"/> Mood Swings <input type="checkbox"/> Headaches <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Dry Hair/Hair Loss <input type="checkbox"/> Short-term Memory Loss <input type="checkbox"/> Frequent Urinary Tract
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- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Painful Joints | <input type="checkbox"/> Inability to Concentrate | <input type="checkbox"/> Dry Skin            | <input type="checkbox"/> Painful Intercourse |
| <input type="checkbox"/> Insomnia       |   | <input type="checkbox"/> 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
Irritability	0	1	2	3	4	5	6	7	8	9	10
Nervousness	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 w/life	0	1	2	3	4	5	6	7	8	9	10	
Symptoms increase if meals 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#: _____
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## 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!*