CUSTOM RX
pharmacy & wellness concepts

Women's Health & Wellness Evaluation

General Information

x______________________________
I acknowledge receipt of Custom Rx's Notice of Privacy Practices

Office Use Only
Date: Time:

Name ______________________ D.O.B.____/____/______ Drivers License#______________ ST_____

Address________________________________ City__________________ ST______ Zip__________

Phone: Home ______________ Work______________ Cell______________ Email________________

Occupation______________________ ❑ Full-time ❑ Part-time ❑ Retired ❑ Unemployed

Relationship Status: ❑ Married ❑ Single ❑ Partnered ❑ Divorced ❑ Widowed

How were you referred to Custom Rx?
❑ Healthcare Provider ❑ Another Patient ❑ Seminar ❑ Advertisement ❑ Other______________

What are your specific goals for this wellness evaluation? ______________________________

____

____

Do you have specific questions about a potential therapy(e.g. Hormone Replacement Therapy)?__________

____

____

Who are your current healthcare providers?

Primary__________________ OB/GYN__________________ Other__________________

Do you have a prescription insurance card? ❑ Yes ❑ No Insurance company______________

Rx Group Number______________ Rx ID Number______________ Bin#__________ PCN#__________

Would you like to receive a monthly email newsletter from Custom Rx? ❑ Yes ❑ No
Would you like to receive prescription refill reminders via text message? ❑ Yes ❑ No

Medical Status

General Health: ❑ Excellent ❑ Good ❑ Fair ❑ Poor Height _______ Weight______ Goal weight______

Drug allergies: ______________________________ Reaction______________________

Allergies to food, chemicals, pollen, other environmental agents, etc.______________________

Family Medical History: (please check all that apply)

❑ Cancer (type)__________________ Person/s in family__________
❑ Diabetes (type)__________________ Person/s in family__________
❑ Heart disease Person/s in family__________
❑ Osteoporosis Person/s in family__________
❑ Other __________________ Person/s in family__________

Medical Status (cont'd)

Personal Medical Conditions: (please check all that apply)

- ❑ Headaches
- ❑ Migraines
- ❑ Stroke
- ❑ Mood Disorder(s)
  - ❑ Depression
  - ❑ Anxiety
  - ❑ Insomnia
  - ❑ Other ____________________
- ❑ Thyroid
- ❑ Swollen glands (e.g. lymph nodes)
- ❑ Asthma
- ❑ Heart Condition
- ❑ Clotting defects
- ❑ High blood pressure
- ❑ Breast lumps
- ❑ Nipple Discharge
- ❑ Uterine/Tubal dysfunction
- ❑ Liver disease
- ❑ Kidney stones/gallstones
- ❑ Acid Reflux/Heartburn
- ❑ Colitis, IBS, or Crohn's
- ❑ Eating disorders
- ❑ Diabetes (type)____________________
- ❑ Varicose veins
- ❑ Anemia
- ❑ Chronic fatigue
- ❑ Fibromyalgia
- ❑ Pain Condition (rate pain 1-10)______
- ❑ Arthritis (type)____________________
- ❑ Fractures (type)____________________
- ❑ Cancer (type) ____________________

❑ Other (explain)____

Surgical History/Hospitalizations/Serious Illnesses (please list year of occurrence)____________________________

____

Current Medications

Drug	Dose (strength)	Frequency	When Started

Vitamins, Supplements, Herbs & OTC Products

Vitamin & Manufacturer	Dose (strength)	Frequency	When Started

If you have ever taken any past medications not listed above (i.e. for sleep, mood disorders, etc.) please list medication and doses____

Have you ever had a mammogram? ❑ Yes ❑ No Date:____________ Results:_______________

Have you ever had a bone density scan? ❑ Yes ❑ No Date:____________ Results:_______________

Have you ever had your thyroid checked? ❑ Yes ❑ No Date:____________ Results:_______________

Have you ever had your cholesterol checked? ❑ Yes ❑ No Date:_____________

Results: Total________, LDL________, HDL________, Triglycerides___________

Gynecological History

Age at first period________ Date of last period_________________

Date of last pelvic examination_______________ Pap smear_____________ Results__________________

Have you ever had an abnormal pap smear? ❑ Yes ❑ No Treatment________________________________

Are you sexually active? ❑ Yes ❑ No

Are you trying to get pregnant? ❑ Yes ❑ No

Are you currently using birth control? ❑ Yes ❑ No Method:_________________ How long?:__________

Problems with it?____ How long?:__________

If you have ever taken hormones (synthetic or natural) that are not listed above, please list medications and doses here____

Since you started having periods:

How many days from start of one period to the start of the next? _______ days

Number of days of flow ______ days Amount of bleeding: ❑ Heavy ❑ Moderate ❑ Light ❑ Spotting

Amount of cramping: ❑ Frequent ❑ Moderate ❑ Infrequent ❑ None

Premenstrual symptoms?____

Starting and ending when?____

Any recent changes in your normal cycle? ❑ Yes ❑ No When?____________________________________

When did the changes begin?____

Any bleeding between periods? ❑ Yes ❑ No When____

Any pelvic pain, pressure, or fullness? ❑ Yes ❑ No Describe__________________________________

Any unusual vaginal discharge or itching? ❑ Yes ❑ No Describe_______________________________

Treatment?____

Any history of vaginal yeast infections? ❑ Yes ❑ No Describe_________________________________

Have you taken antibiotics in the past year? ❑ Yes ❑ No Describe______________________________

Age at first pregnancy? _______ How many full-term pregnancies?_______

Problems?____

Any interrupted pregnancies? (miscarriages) ❑ Yes ❑ No

Have you had a tubal ligation? ❑ Yes ❑ No When?________________________

Has your partner had a vasectomy? ❑ Yes ❑ No

Have you had a hysterectomy? ❑ Yes ❑ No When?_____________ Why?__________________________

Have you had your ovaries removed? ❑ Yes ❑ No When?_____________ Why?______________________

Lifestyle Factors

Check the meals you eat on a daily basis:

❑ Breakfast ❑ Mid-morning snack ❑ Lunch ❑ Afternoon snack ❑ Dinner ❑ Late-night snack Other:______________

Typical daily menu (24 hour diet recall)

Breakfast____

a.m. Snack____

Lunch____

p.m. Snack____

Dinner____

Late night snack____

Do you eat red meat? ❑ Yes ❑ No Number of meals per week:_________ Kind______________________

Do you drink milk? ❑ Yes ❑ No Number of glasses per week:______ or per day:______ kind____________

Do you eat cheese? ❑ Yes ❑ No Number of times per week:_______ or per day:_______

Do you drink coffee? ❑ Yes ❑ No Number of cups per week:_______ or per day:_______

Do you drink tea? ❑ Yes ❑ No Number of cups per week:_______ or per day:_______

Do you drink soda? ❑ Yes ❑ No Number of cans per week:_______ or per day:_______ kind___________

How much water do you drink per day?____________ ounces

Sweets - what sweets do you usually eat and how much?_______________________________________

Flour - what kind and how much (e.g. bread, pasta, pizza, baked goods, etc.)?______________________

____

Sources of fat and how much (e.g. margarine, butter, cooking oils, mayo, etc.) ______________________

____

How many servings of fruits do you eat per day?_____________ Vegetables?____________

What are your favorite foods?____

What time do you usually wake up?_________________ What time do you go to bed?_________________

What is your sleep pattern (e.g. trouble falling asleep, waking at night, restless leg, racing mind)?___________

____

On average, how many hours are you asleep each night?_____________

Do you get physical exercise? ❑ Yes ❑ No What type?________________________How often?_____________

Do you use tobacco products? ❑ Yes ❑ No How much?_______Previously?________How long?_____________

Do you use alcohol products? ❑ Yes ❑ No How much?_______Previously?________How long?_____________

How many bowel movements per day?_________ Color?________________ Consistency?____________________

Hormone Symptom List

Patient Name______________________

Indicate the symptoms you are currently experiencing. You will fill out Week 4 - 16 as you progress through the course of your BHRT.

Scale: 0 = No symptom 1=Mild symptom 2 = Moderate symptom 3 = Severe symptom

Symptoms	Currently Date:	Week 4 Date:	Week 8 Date:	Week 12 Date:	Week 16 Date:
Hot flashes	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Night sweats	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Foggy thinking	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Memory lapses	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Tearful	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Depressed	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Dry skin	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Sleep disturbances	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Heart palpitation	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Vaginal Dryness	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Headaches	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Mood swings (PMS)	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Tender breasts	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Water retention	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Nervous	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Anxious	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Nails breaking or brittle	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Thinning skin	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Fibrosystic breasts	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Weight gain - hips	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Weight gain - waist	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Bleeding changes	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Cold body temperature	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Heavy menses	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Cramping	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Stress	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Sugar craving	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Salt Craving	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Lightheadedness	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Low sex drive	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Difficulty climaxing	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Pain with intercourse	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Fatigue - Morning	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Fatigue - Evening	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Aches/pains	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Incontinence	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Decreased muscle mass	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Increased facial hair	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Constipation	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Diarrhea	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Increased body hair	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Loss of scalp hair	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Acne	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Dry eyes	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Oily skin	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Irritable	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3