Female Hormone Replacement
Confidential *Follow-Up* Evaluation

The answers provided in the questions below will allow the pharmacist to maintain your medical history and will help in advising you about current therapies for hormone replacement. All information will be kept confidential.

General Information

Today's Date: _____

Name: _____ Age:_____ Birth Date:_____

Medical Status

Overall satisfaction with HRT? Excellent _____ Good _____ Fair _____ Poor _____

General Health: Excellent _____ Good _____ Fair _____ Poor _____ Weight: _____ Height: _____

New diagnosis or medical conditions since last appointment: _____

_____

Medication History

Current Hormone Strength How you use it

_____

_____

_____

Medication Name (Rx and OTC) Strength How often per day Date Started

_____

_____

_____

_____

Habits

Any changes in Diet/Meal Plan since last visit?_____

How often and how much?

Do you get physical exercise? Yes ❑ No ❑ _____

Do you use tobacco products? Yes ❑ No ❑ _____

Do you use alcohol products? Yes ❑ No ❑ _____

Do you use caffeine products? Yes ❑ No ❑ _____

Stress Level: High_____ Moderate _____ Low _____

Gynecological History

Have you had a hysterectomy? Yes ❑ No ❑ Date of Last period: _____ Last Pelvic Exam:_____

Symptoms I

For Symptoms I, II, and III: Have you experienced any of the following symptoms recently? Please circle the number that best describes *your* experiences using the following scale-
1 = absent/not a problem, 5 = moderate, 10 = severe.

	ABSENT				MODERATE					SEVERE
Hot flashes (____/day)	1	2	3	4	5	6	7	8	9	10
Night sweats (____/night)	1	2	3	4	5	6	7	8	9	10
Shortness of breath	1	2	3	4	5	6	7	8	9	10
Irregular menses	1	2	3	4	5	6	7	8	9	10
Headaches	1	2	3	4	5	6	7	8	9	10
Mood swings	1	2	3	4	5	6	7	8	9	10
Depression	1	2	3	4	5	6	7	8	9	10
Anxiety	1	2	3	4	5	6	7	8	9	10
Short term memory loss	1	2	3	4	5	6	7	8	9	10
Sleep disorders, insomnia	1	2	3	4	5	6	7	8	9	10
Time to bed:										
Vaginal dryness	1	2	3	4	5	6	7	8	9	10
Vaginal shrinking	1	2	3	4	5	6	7	8	9	10
Painful intercourse	1	2	3	4	5	6	7	8	9	10
Inability to reach orgasm	1	2	3	4	5	6	7	8	9	10
Frequent urinary tract infections	1	2	3	4	5	6	7	8	9	10
Frequent yeast infections	1	2	3	4	5	6	7	8	9	10
Dry hair	1	2	3	4	5	6	7	8	9	10
Hair loss	1	2	3	4	5	6	7	8	9	10
Dry skin	1	2	3	4	5	6	7	8	9	10
Heart palpitations	1	2	3	4	5	6	7	8	9	10
Muscle pain/weakness	1	2	3	4	5	6	7	8	9	10
Joint pain	1	2	3	4	5	6	7	8	9	10

Symptoms II

	ABSENT									SEVERE
Fuzzy thinking	1	2	3	4	5	6	7	8	9	10
Inability to concentrate	1	2	3	4	5	6	7	8	9	10
Depression	1	2	3	4	5	6	7	8	9	10
Emotional swings	1	2	3	4	5	6	7	8	9	10
Irritability	1	2	3	4	5	6	7	8	9	10
Food cravings	1	2	3	4	5	6	7	8	9	10
Heavy menses	1	2	3	4	5	6	7	8	9	10
Uterine fibroids	1	2	3	4	5	6	7	8	9	10
Fibrocystic breasts	1	2	3	4	5	6	7	8	9	10
Swollen breasts	1	2	3	4	5	6	7	8	9	10
Painful breasts	1	2	3	4	5	6	7	8	9	10
Bloating	1	2	3	4	5	6	7	8	9	10
Water retention	1	2	3	4	5	6	7	8	9	10
Weight gain	1	2	3	4	5	6	7	8	9	10
Cramps	1	2	3	4	5	6	7	8	9	10

Symptoms II

	ABSENT									SEVERE
Fatigue	1	2	3	4	5	6	7	8	9	10
Lack of energy	1	2	3	4	5	6	7	8	9	10
Loss of sex drive	1	2	3	4	5	6	7	8	9	10
Inability to concentrate	1	2	3	4	5	6	7	8	9	10
Vocal changes	1	2	3	4	5	6	7	8	9	10
Increased facial hair	1	2	3	4	5	6	7	8	9	10
Enlarged clitoris	1	2	3	4	5	6	7	8	9	10
Acne/Roseacea	1	2	3	4	5	6	7	8	9	10
High blood pressure	1	2	3	4	5	6	7	8	9	10

Symptoms IV

	ABSENT					MODERATE				SEVERE
Constipation	1	2	3	4	5	6	7	8	9	10
Brittle nails	1	2	3	4	5	6	7	8	9	10
Nighttime urination	1	2	3	4	5	6	7	8	9	10
Increased hunger	1	2	3	4	5	6	7	8	9	10
Increased thirst	1	2	3	4	5	6	7	8	9	10
Dry eyes	1	2	3	4	5	6	7	8	9	10
Rapid aging	1	2	3	4	5	6	7	8	9	10
Change in height	1	2	3	4	5	6	7	8	9	10

Patient questions or concerns