# 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 about current medical therapies for hormone replacement. All information provided 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: _____

_____

## Medication History

**please bring all medications and natural products to your appointment**

| **Current Hormone** | **Strength** | **How you use it** |
|---|---|---|
| | | |
| | | |
| | | |

| **Medication Name** | **Strength** | **How often per day** | **Date Started** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## Habits

Any Changes to Diet/Meal Plan:_____

How much water do you drink in a day? _____

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 _____

General causes/duration of stress: _____

## 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: | | | | | Time to wake: | | | | | |
| Do you fall asleep quickly? | | | | | How often do you wake? | | | | | |
| 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 or joint pain* | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

## Symptoms II

| | ABSENT | | | | | MODERATE | | | | 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 (how much?___)* | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Cramps | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

## Symptoms II

| | ABSENT | | | | | MODERATE | | | | SEVERE |
|---|---|---|---|---|---|---|---|---|---|---|
| *Fatigue* | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Best time of day: | | | | | Worst time of day: | | | | | |
| 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 |

## 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 |
| Cold hands and feet | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

## Patient questions or concerns