

Compound Pharmaceutical Technologies, Inc. 1048 Stanton Road, Suite B Daphne, AL 36526 Phone Local: 251-626-2820 Phone Toll Free: 866-591-6337 Fax: 866-684-6337 www.cptinc.org

CONFIDENTIAL FEMALE HORMONE EVALUATION

Today's Date:

Name:				Birthdate:	Age:	
Address:	Street			City	State	Zip
Phone:			Email:			
Height:	Weigh	nt:	Desired Weight:			
Allergies: Please list a	□Yes □Yes □Yes □Yes	□No □No □No	If yes, describe: If yes, describe: If yes, describe: If yes, describe: describe the reactio	n that occurred		
Drugs: Foods: Other:						

Over-the-Counter Medication History: Please list all non-prescription medications that you are taking. (Include vitamins, herbals, and supplements):

Medical Conditions/Diseases: Please list any conditions/diseases that you have been diagnosed with or suffer from. (Examples include: Heart disease, high blood pressure, depression, ulcers, arthritis, insomnia, etc)

Current Prescription Medications (including hormones): Medication Name Strength

Date Started

How Often per day

Patient Name:

			Fatient Na	ine.		
List Hormones F Na	Previous me	ily Taken:	Date Started	Date Stopped	Reason	
Have you ever u If you experienc		•	s (birth control)? □Y se describe:	es □No		
How many preg	nancies	have you had?	How many childre	en? Any Interrupte	d pregnancies? Yes	No
•	tubal lig	-	\Box No If yes, date of \Box No If yes, date of			
Do you have a fa	•		in? □Yes □ No cers or osteoporosis?	Please list the family	/ member(s):	
Have you had a	ny of the	e following tes	ts performed?			
Mammography	□Yes	□No	Date:	Outcome:		
PAP Smear	□Yes	□No	Date:	Outcome:		
Bone Density	□Yes	□No	Date:	Outcome:		
What age did yo	our perio	od start?	How many days i	s/was your cycle (Exa	ample: 28):	
Is/was your me	Is/was your menstrual flow heavy or light? Any clots? Yes No					
Have you ever had what YOU would consider to be abnormal cycles? \Box Yes \Box No						
Explain:						
When was your	•					
How many days				()		
-	you eve	r suffered from	Premenstrual Syndro	ome (PMS) symptom	s? ∟Yes ∟ No	
Explain:	:					
Describe your d		2				
How many mea How many vege	-	-	Sveh			
			uay:			
How much fruit do you eat per day? How much protein do you eat per day?						
How much red meat do you eat per day?						
How much sugar or starches per day?						
How many wheat products per day?						
How many snacks per day?						

Patient Name:

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Aches & Pains	Thinning Skin				
Bone Loss	Aches & Pains				
	Bone Loss				

Patient Name: .

Do you have work related stress? 🗌 Yes 🛛 No
If yes, explain:
Do you have financial related stress? 🗌 Yes 🛛 No
Do you have relationship related stress? 🗌 Yes 🛛 No
Have you had any stress full event or traumatic event in the past? $\ \square$ Yes $\ \square$ No
Have had any illnesses related to any type of infection in the past? \square Yes \square No
Have you had any type of surgery in the past? \Box Yes \Box No
Do you have difficulty sleeping? 🗆 Yes 🛛 No
If yes, explain?
What time do you typically go to bed?
What time do you typically fall asleep?
Do you work any type of shift work? 🗆 Yes 🛛 No
If yes, explain?
Have you dieted in the past? \Box Yes \Box No
How often do you diet?
When was the last time you dieted?
Have you been diagnosed with diabetes? 🗌 Yes 🛛 No
Are you insulin resistant? 🗌 Yes 🛛 No 🗌 Do not know
Do you have high cholesterol? 🗌 Yes 🛛 No
Do you have high triglycerides? 🗌 Yes 🗌 No
Do you have high blood pressure? 🗆 Yes 🛛 No
What are your goals for taking Hormone Replacement Therapy?
1.
2.
3.
4.
5.
6.
Doctor that we should contact for this therapy:
Name: Phone:
Address:
Street City State Zip

*** Please email a copy to cwells@cptinc.org or fax to 1-866-684-6337. Please include a copy of all relevant lab work, especially hormone levels that you have recently obtained.