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CONFIDENTIAL FEMALE HORMONE EVALUATION

Today's Date:

Name:		Birthdate:	rthdate:	Age:	
Address:	_				
	Street		City	State Zip	
Phone:		Email:			
Height:	Weight:	Desired Weight:			
How Often and how mu Do you use tobacco? Do you use alcohol? Do you use caffeine? Do you exercise?	Yes □No Yes □No	If yes, describe: If yes, describe: If yes, describe: If yes, describe:			
Allergies: Please list any Drugs: Foods: Other:	/ allergies and	describe the reaction	:hat occurred		
Over-the-Counter Meditaking. (Include vitamin	•	·	scription medications	s that you are	
Medical Conditions/Dis or suffer from. (Example insomnia, etc)		•	•	•	
Current Prescription Mo	edications (inc	luding hormones): Strength	Date Started	How Often per day	

Patient Name: List Hormones Previously Taken: Date Started Name Date Stopped Reason Have you ever used oral contraceptives (birth control)? \square Yes \square No If you experienced any problems, please describe: How many pregnancies have you had? How many children? Any Interrupted pregnancies? Yes If yes, please explain: Have you had a tubal ligation? \square Yes \square No If yes, date of surgery: Have you had a hysterectomy? \square Yes \square No If yes, date of surgery: Reason: Do your ovaries remain? \square Yes \square No Do you have a family history of any cancers or osteoporosis? Please list the family member(s): Have you had any of the following tests performed? Mammography □Yes □No Date: Outcome: □Yes □No PAP Smear Date: Outcome: Bone Density \square Yes \square No Date: Outcome: What age did your period start? How many days is/was your cycle (Example: 28): Is/was your menstrual flow heavy or light? Any clots? ☐ Yes ☐ No Have you ever had what YOU would consider to be abnormal cycles? \square Yes \square No Explain: When was your last period? How many days did it last? Do you or have you ever suffered from Premenstrual Syndrome (PMS) symptoms? \square Yes \square No Explain: Describe your diet: How many meals per day?

No

How many vegetables do you eat per week?

How much fruit do you eat per week?

How much protein do you eat per week?

How much red meat do you eat per week?

How much sugar or starches per week?

Patient Name:

SYMPTOM	NONE	MILD	MODERATE	SEVERE
Hot Flashes				
Night Sweats				
Vaginal Dryness				
Painful Intercourse				
Incontinence				
Irregular Periods				
Uterine Fibroids				
Water Retention				
Tender Breasts				
Fibrocystic Breasts				
Increased Forgetfulness				
Foggy Thinking				
Tearful			-	
Depressed				
Mood Swings			<u> </u>	
Stress				
Morning Fatigue				
Evening Fatigue				
Difficulty Sleeping				
Decreased Stamina Anxious				
Irritable				
Nervous				
Ringing in Ears				
Fibromyalgia				
Allergies				
Headaches				
Sugar Cravings				
Dizzy Spells				
Cold Body Temperature				
Goiter				
Hoarseness				
Hair Dry or Brittle				
Nails Breaking or Brittle				
Constipation				
Slow Pulse Rate				
Rapid Heartbeat				
Heart Palpitations				
Infertility Concerns				
Acne				
Increased Facial/Body Hair				
Scalp Hair Loss				
Weight Gain-Hips				
Weight Gain-Waist				
High Cholesterol				
Elevated Triglycerides				
Decreased Libido				
Decreased Muscle Mass				
Decreased Flexibility				
Burned Out Feeling				
Increased Joint Pain				
Neck or Back Pain				
IBS				
Thinning Skin				
Rapid Aging				
Aches & Pains				
Bone Loss				

	Patient Name: .					
Do you have work related stress? \square Yes \square I	No					
If yes, explain:						
Do you have financial related stress? $\ \square$ Yes	□ No					
Do you have relationship related stress? \square Yes \square No						
Have you had any stress full event or traumatic event in the past? \Box Yes \Box No						
Have had any illnesses related to any type of infection in the past? \Box Yes \Box No						
Have you had any type of surgery in the past? \square Yes $\ \square$ No						
Do you have difficulty sleeping? \square Yes \square 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? \square Yes	□ No					
If yes, explain?						
Have you dieted in the past? \square Yes \square No						
How often do you diet?						
When was the last time you dieted?						
Have you been diagnosed with diabetes? \square	∕es □ No					
Are you insulin resistant? \square Yes \square No \square Do	o not know					
Do you have high cholesterol? \square Yes \square No						
Do you have high triglycerides? $\ \square$ Yes $\ \square$ No						
Do you have high blood pressure? \square Yes \square No						
What are your goals for taking Hormone Replac	ement 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.