



# Medical History Form

Please return your form to the Pharmacy when you have finished.  
The Pharmacists will meet with you to review your information. Thank you.

## 1. Patient Information:

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_

Birth date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_

Home / Work Phone #: \_\_\_\_\_

Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Would like to receive our monthly newsletter?

Yes

No

Email Address: \_\_\_\_\_

## 2. Please list each doctor from whom you seek care, including address and phone number, if known.:

Doctor Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Doctor Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Doctor Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

## 3. Over-the-counter (OTC) issues:

Please check all products that you use occasionally or regularly. Check all that apply.

Pain reliever

Combination product (cough+cold reliever.)(Example: Triaminic DM)

Aspirin

Sleep Aids (Examples: Excedrin PM, Unisom, Somnex, Nytol)

Acetamorphin (Example: Tylenol)

Antidiarrheals (Examples: Imodium, Pepto Bismol, Kaopectate)

Ibuprofen (Example: Motrin IB)

Laxatives/stool softeners (Examples: Doxidan, Correctol, etc.)

Naproxen (Example: Aleve)

Diet aids/weight loss products (Example: Dexatrim)

Ketoprofen (Example: Orudis KT)

Antacids (Examples: Maalox, Mylanta)

Cough Suppressant (Example: Robitussin DM)

Acid blockers (Examples: Tafamet HB, Pepcid AC, Zantac 75)

Decongestant product (Example: Sudafed)

Other (Please List) \_\_\_\_\_

## 4. Medical Conditions / Diseases. Please Check all that apply to you.

Heart Disease (example: Congestive Heart Failure)

Lung condition (example: asthma, emphysema, COPD)

High Cholesterol or lipids (examples: Hyperlipidemia)

Diabetes

High Blood Pressure (example: Hypertension)

Arthritis or joint problems

Cancer

Depression

Ulcers (stomach, esophagus)

Epilepsy

Thyroid Disease

Headaches / Migraines

Hormonal Related issues

Eye Disease (glaucoma, etc.)

Blood Clotting Problems

Other. Please List: \_\_\_\_\_

Patient Name: \_\_\_\_\_ SS #: \_\_\_\_\_

5. Family History of Diabetes: Yes No

6. Family History of Heart Disease Yes No

7. Family History of Hormonal Cancer Yes No

What type of cancer: \_\_\_\_\_ Who: \_\_\_\_\_

8. Have you had a bone density scan? Yes No Date: \_\_\_\_\_

Results: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Date of last exam: \_\_\_\_\_

9. Drug Allergies: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**10. Prescription Medications:** Please list all prescription medications you are currently using, Be sure to include any mail order or physician samples.

<u>Medication Name</u>	<u>Dose</u>	<u>How many times per day?</u>	<u>Doctor</u>
1. _____			
2. _____			
3. _____			
4. _____			
5. _____			
6. _____			

Patient Name: \_\_\_\_\_ SS #: \_\_\_\_\_

## Hormone Replacement Therapy Specific Information

1. How did you arrive at the decision to consider Prescription Natural Hormone Replacement Therapy?

Doctor

Self

Friend / family member

2. Bone Size:  Small

Medium

Large

3. Have you ever used oral contraceptives?  NO  YES

3a. If YES, any Problems?  NO  YES

4. How many pregnancies have you had? \_\_\_\_\_

4a. How many children? \_\_\_\_\_

5. Have you had a hysterectomy?  NO  YES

5a. If YES, Date of surgery: \_\_\_\_\_  Total  Uterus Only

6. Have you had a tubal ligation?  NO  YES

7. Were you prematurely gray?  NO  YES

8. Have you had any of the following tests performed? Check those that apply and note date of last test.

Mammography  No  Yes Date: \_\_\_\_\_

Pap Smear  No  Yes Date: \_\_\_\_\_

9. When was your last period? \_\_\_\_\_

10. How many days did it last? \_\_\_\_\_

11. Do you have, or did you ever have Premenstrual Syndrome (PMS)?  No  Yes

11a. If YES, explain Symptoms:

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Patient Name: \_\_\_\_\_ SS #: \_\_\_\_\_

## Hormone Replacement Therapy Specific Information

12. Do you take hormones of any kind? \_\_\_\_\_

If so, list (include birth control pills or natural hormone cream):

Type	Dose	Do they help your symptoms	How often do you use them?	How long have you used them?

13. Have you tried other hormones? \_\_\_\_\_ If so, list:

What kind?	What dose?	How they affected you?

14. Do you have ovaries?      Yes      No

Date of last period:

Describe your periods (For example: Are your periods regular? How many days from start of one period to the start of the next one? Number of days of flow? Describe your flow. Any bleeding between periods? Do you have clots?)

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15. Do you have a history of vaginal/bladder infections?

\_\_\_\_\_

16. Have you ever had a miscarriage(s)? \_\_\_\_\_ When \_\_\_\_\_

17. Do you have trouble sleeping: \_\_\_\_\_ No \_\_\_\_\_ Yes, please describe: how long had this been a problem?, can you go to sleep but then wake up, have mind racing at night, etc.

18. Do you have PMS symptoms?      Yes      No  
 If yes, when do symptoms start and stop:  
 \_\_\_\_\_

**PMS Patients please fill in this section:**

PMS-A	PMS-H	PMS-C	PMS-D
___ Nervous tension	___ Weight gain	___ Headache	___ Depression
___ Mood swings	___ Water retention	___ Cravings	___ Forgetfulness
___ Irritability	___ Breast tenderness	___ Heart palpitations	___ Crying
___ Anxiety	___ Bloating	___ Fatigue	___ Insomnia

# DIET / LIFESTYLE

1. Dietary Restrictions:

\_\_\_\_\_  
\_\_\_\_\_

**Describe typical meal choices:**

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

2. Do you get regular exercise? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please describe:

\_\_\_\_\_  
\_\_\_\_\_

3. Stress Level: High \_\_\_\_\_ Moderate: \_\_\_\_\_ None: \_\_\_\_\_

**STRESS MANAGEMENT:** Do you practice any stress management techniques? \_\_\_\_\_ YES \_\_\_\_\_ NO  
If YES, describe what you do and how often?

4. Do you experience low blood sugar symptoms or hypoglycemia? \_\_\_\_\_ For example:

5. Do you get shakie, dizzy, or irritable if you do not eat or eat sugar? \_\_\_\_\_ Yes \_\_\_\_\_ No

Current Supplements: (include milligrams/dosages):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Number of regular bowel movements on a daily basis?

\_\_\_\_\_

**Lifestyle Information:**

	Do you use? Yes or No	If YES, how often and how much?
Tobacco (Smoke, chew, dip)		
Alcohol (beer, wine, hard liquor)		
Caffeine (cola drinks, tea, coffee)		

3. General Health:      Good              Fair              Poor

4. Energy Level:      High              Fairly High      Low

5. Blood Pressure: \_\_\_\_\_

6. Cholesterol Level: (If Known): Total: \_\_\_\_\_ Date: \_\_\_\_\_

HDL: \_\_\_\_\_ LDL: \_\_\_\_\_ Triglycerides: \_\_\_\_\_

**IMPAIRMENTS:** Check if you have any of the following:

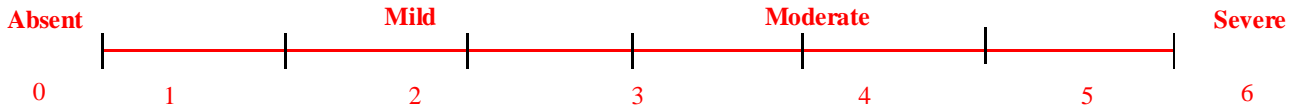
\_\_\_\_\_ Physical Impairment      \_\_\_\_\_ Visual Impairment      \_\_\_\_\_ Hearing Impairment

**EXERCISE:** Do you exercise regularly? \_\_\_\_\_ YES      \_\_\_\_\_ NO



# Patient Symptom Severity Chart

Please read the following list of symptoms and rate their severity on the corresponding lines using the following keys:



Date	/ /	/ /	/ /	/ /
	<b>Today</b>	<b>Follow-up 1</b>	<b>Follow-up 2</b>	<b>Follow-up 3</b>
<b>Symptoms of Low Estrogen</b>				
Dry Skin	_____	_____	_____	_____
Heart Palpitations	_____	_____	_____	_____
Hot Flashes	_____	_____	_____	_____
Inability to reach climax	_____	_____	_____	_____
Night sweats	_____	_____	_____	_____
Painful intercourse	_____	_____	_____	_____
Sleep disturbances	_____	_____	_____	_____
Urinary incontinence	_____	_____	_____	_____
Urinary tract infections (UTI's)	_____	_____	_____	_____
Yeast infections	_____	_____	_____	_____
<b>Symptoms of Low Progesterone</b>				
Anxiety	_____	_____	_____	_____
Cramping	_____	_____	_____	_____
Insomnia	_____	_____	_____	_____
Irregular menses	_____	_____	_____	_____
Joint Pain	_____	_____	_____	_____
Mood swings	_____	_____	_____	_____
PMS	_____	_____	_____	_____
Swollen breasts	_____	_____	_____	_____
Water retention	_____	_____	_____	_____
Weight gain	_____	_____	_____	_____
<b>Symptoms of Low Testosterone</b>				
Blunted motivation	_____	_____	_____	_____
Diminished feeling of well-being	_____	_____	_____	_____
Fatigue, prolonged	_____	_____	_____	_____
General aches and pains	_____	_____	_____	_____
Muscle weakness	_____	_____	_____	_____
<b>Symptoms of Both Low Estrogen and Testosterone</b>				
Thinning skin	_____	_____	_____	_____
Vaginal dryness	_____	_____	_____	_____
<b>Symptoms of Low Estrogen, Progesterone, and/or Testosterone</b>				
Depression	_____	_____	_____	_____
Fuzzy thinking	_____	_____	_____	_____
Hair loss	_____	_____	_____	_____
Headaches	_____	_____	_____	_____
Irritability	_____	_____	_____	_____
Low sex drive	_____	_____	_____	_____
Memory lapses	_____	_____	_____	_____



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### Pharmacy Record Release Authorization

I, undersigned patient, authorize my pharmacist to release my personal medication and/or other medical information to my health care provider upon request or as deemed necessary.

I understand that employees of Ward Drug Company Pharmacy will protect my privacy and this information will be released to other health care professionals only when it is necessary in order to provide health care services to me. This authority shall continue until revoked by me in writing.

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Patient Name: _____ SS#: _____
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