MEDICATION PROBLEM SOLVERS

Kubat PHARMACY, INC.
CUSTOM COMPOUNDING
EVERYTHING MEDICAL
Dedication to excellence and service since 1935

4924 Center Street
Omaha, Ne 68106
Phone: 402-558-2474
Fax: 402-561-1252

Natural Hormone Replacement Confidential Evaluation

From a clinical management point of view, it is very useful to gain a detailed history of possible hormone deficiencies. 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. All information provided will be kept confidential.

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GENERAL INFORMATION

Date:_____

Name:_____ Age:_____ Birth date:_____

Address:_____

Home phone:_____ Work phone:_____

Occupation:_____ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Other ☐

Living Situation: Spouse ☐ Alone ☐ Partner ☐ Friend(s) ☐ Parents ☐ Children ☐ Other ☐

Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐

Pets:_____

How did you hear about Natural Hormone Replacement Therapy? Ad ☐ Another patient ☐
Courses/Seminars ☐ Physician/Healthcare practitioner ☐ Books/Articles ☐ Other ☐

Do you understand what Natural Hormone Replacement is?_____

_____

What are your goals for Natural Hormone Replacement?_____

_____

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MEDICAL STATUS

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

Current diagnosis or medical conditions:_____

_____

Drug allergies:_____

_____

Allergies to food, pollen, etc:_____

_____

Current Medications:_____

_____

Current vitamins or OTC products:_____

_____

Current Herbs/etc:_____

_____

Have you ever had your cholesterol level checked? Yes ☐ No ☐ Date:_____ Results:_____

Have you ever had your Hemoglobin A1C checked Yes □ No □ Date:_____ Results: _____

Have you ever had a PSA test? Yes □ No □ Date:_____ Results: _____

Have you ever had a bone density scan? Yes □ No □ Date:_____ Results:_____

Current/Recent Health Care Providers:_____

_____

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PAST MEDICAL CONDITIONS

Childhood diseases:_____

Heart Trouble □ High Blood Pressure □ Stroke □ Varicose Veins □ Clotting Defects □

Diabetes □ Kidney Trouble □ Epilepsy □ Fractures □ Arthritis □ Colitis □ Cancer □

Gallbladder Trouble □ Asthma □ Chronic Fatigue □ Fibromyalgia □ Eating Disorder □

Psoriasis □ Eczema□

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HABITS

Dietary Restrictions:_____

Meal Choices: Breakfast:_____

Lunch:_____

Dinner:_____

Do you get routine physical exercise?_____ What type?_____

Do you use tobacco products?_____ How much?_____ Previously:_____ How long:_____

Do you use alcohol products?_____ How much?_____ Previously:_____ How long:_____

Do you use caffeine products?_____ How much?_____

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FAMILY HISTORY

Please list family member and their ages who are still living that may have important disease such as: High Blood Pressure, Heart Disease, Cancer, Diabetes, Osteoporosis, etc:_____

_____

_____

_____

Please list family members who died of important of important diseases (see previous question) and their age at the time of death:_____

_____

_____

SYMPTOMS I

Rate your current status for each symptom by checking the appropriate modifier. Please feel free to use additional space to describe any symptom. This section may be repeated upon subsequent visits.

	Absent	Mild	Moderate	Severe
Joint pain/muscular ache				
Low libido				
Nervousness				
Anxiety				
Depression				
Irritability				
Increased need for sleep, often tired				
Insomnia				
Physical exhaustion/lack of vitality				
Weight gain				
Decrease in muscular strength				
Inability to concentrate				
Decrease in mental sharpness				

SYMPTOMS II

	Absent	Mild	Moderate	Severe
Excessive Sweating				
Feeling you have passed your peak				
Feeling burnt out of having hit rock bottom				
Decrease in beard growth				
Decrease in ability/frequency to perform sexually				
Inability to reach orgasm				

CONSULTATION NOTES