



# Vital Care Compounder

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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.



## GENERAL INFORMATION

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

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Work Phone No. \_\_\_\_\_ Cell 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?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## MEDICAL STATUS

General Health: Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Current diagnosis or medical conditions: \_\_\_\_\_  
 \_\_\_\_\_

Drug Allergies: \_\_\_\_\_  
 \_\_\_\_\_

Allergies to food, pollens, etc: \_\_\_\_\_  
 \_\_\_\_\_

Current Medications \_\_\_\_\_  
 \_\_\_\_\_

Current Vitamins or OTC products: \_\_\_\_\_  
 \_\_\_\_\_

Current Herbs/etc: \_\_\_\_\_  
 \_\_\_\_\_

Have you ever had your cholesterol level checked: \_\_\_\_\_ Date: \_\_\_\_\_ Results: \_\_\_\_\_

Have you ever had a mammogram: \_\_\_\_\_ Date: \_\_\_\_\_ Results: \_\_\_\_\_

Have you ever had a bone density scan: \_\_\_\_\_ Date: \_\_\_\_\_ Results: \_\_\_\_\_

Current / Recent Health Care Providers: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PAST MEDICAL CONDITIONS**

Childhood diseases: \_\_\_\_\_  
Heart Trouble: \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Stroke \_\_\_\_\_ Varicose Veins \_\_\_\_\_  
Clotting Defects \_\_\_\_\_ Diabetes \_\_\_\_\_ Kidney Trouble \_\_\_\_\_ Epilepsy \_\_\_\_\_ Fractures \_\_\_\_\_  
Arthritis \_\_\_\_\_ Colitis \_\_\_\_\_ Gallbladder Trouble \_\_\_\_\_ Asthma \_\_\_\_\_ Chronic Fatigue \_\_\_\_\_  
Fibromyalgia \_\_\_\_\_ Eating Disorder \_\_\_\_\_ Cancer \_\_\_\_\_

**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: \_\_\_\_\_

**FAMILY HISTORY**

Please list family members which are still living (and their ages) that may have important diseases such as high blood pressure, heart disease, cancer, diabetes, osteoporosis, etc.: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list family members who died of any of the diseases listed above and their age at the time of death: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**GYNECOLOGICAL HISTORY**

Age at first period: \_\_\_\_\_ Date of last period: \_\_\_\_\_  
Date of last pelvic exam: \_\_\_\_\_ and Pap smear: \_\_\_\_\_ Results: \_\_\_\_\_  
Have you ever had an abnormal pap smear? \_\_\_\_\_ Treatment \_\_\_\_\_  
Are you sexually active? \_\_\_\_\_ Are you trying to get pregnant? \_\_\_\_\_  
Current birth control method: \_\_\_\_\_ How long: \_\_\_\_\_  
Problem with it: \_\_\_\_\_ How long: \_\_\_\_\_  
Past birth control and any related problems: \_\_\_\_\_  
How many days from start of one period to start of the next: \_\_\_\_\_

Number of days of flow: \_\_\_\_\_ Amount of bleeding: \_\_\_\_\_

Amount of cramps: \_\_\_\_\_

Premenstrual symptoms: \_\_\_\_\_

Starting and ending when: \_\_\_\_\_

Any current changes in your normal cycle: \_\_\_\_\_

Any bleeding between periods: \_\_\_\_\_ When: \_\_\_\_\_

Any pelvic pain, pressure or fullness: \_\_\_\_\_ Describe: \_\_\_\_\_

Any unusual vaginal discharge or itching: \_\_\_\_\_ Describe: \_\_\_\_\_

Treatment: \_\_\_\_\_

Age at first pregnancy: \_\_\_\_\_

How many full term pregnancies: \_\_\_\_\_ Problems \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any interrupted pregnancies (miscarriages or abortions) \_\_\_\_\_

\_\_\_\_\_

Have you had a tubal ligation: \_\_\_\_\_ When: \_\_\_\_\_

Have you had any part or whole ovary removed: \_\_\_\_\_ When \_\_\_\_\_

Have you had a hysterectomy: \_\_\_\_\_ When \_\_\_\_\_

Do your ovaries remain: \_\_\_\_\_

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## **SYMPTOMS**

### EXCESS PROGESTERONE

SYMPTOM	ABSENT	MILD	MODERATE	SEVERE
DEPRESSION				
SOMNOLENCE				

### EXCESS ESTROGEN

SYMPTOM	ABSENT	MILD	MODERATE	SEVERE
WATER RETENTION				
FATIGUE				
BREAST SWELLING				
FIBROCYSTIC BREASTS				
PREMENSTRUAL – LIKE MOOD SWINGS				
LOSS OF SEX DRIVE				
HEAVY OR IRREGULAR MENSES				
UTERINE FIBROIDS				
CRAVING FOR SWEETS				
WEIGHT GAIN				

LACK OF PROGESTERONE

<b>SYMPTOM</b>	<b>ABSENT</b>	<b>MILD</b>	<b>MODERATE</b>	<b>SEVERE</b>
HEADACHE				
LOW LIBIDO				
ANXIETY				
SWOLLEN BREASTS				
MOODINESS				
FUZZY THINKING				
DEPRESSION				
FOOD CRAVINGS				
IRRITABILITY				
INSOMNIA				
CRAMPS				
EMOTIONAL SWINGS				
PAINFUL BREASTS				
WEIGHT GAIN				
BLOATING				
INABILITY TO CONCENTRATE				
EARLY MENSTRUATION				
PAINFUL JOINTS				
ASTHMA				
ACNE				

LACK OF ESTROGEN

<b>SYMPTOM</b>	<b>ABSENT</b>	<b>MILD</b>	<b>MODERATE</b>	<b>SEVERE</b>
HOT FLASHES				
SHORTNESS OF BREATH				
NIGHT SWEATS				
SLEEP DISORDERS				
VAGINAL DRYNESS				
DRY SKIN				
ANXIETY				
MOOD SWINGS				
HEADACHE				
DEPRESSION				
MEMORY LOSS				
HEART PALPITATIONS				
YEAST INFECTIONS				
VAGINAL SHRINKAGE				
PAINFUL INTERCOURSE				
INABILITY TO REACH ORGASM				
LACK OF MENSTRUATION				