NEXTGEN Rx
COMPOUNDING PHARMACY

New Life. New You. ***Next Generation.***

Consultation Date: ____/____/_____

Patient Name:_____ DOB: ____/____/_____ Age: _____ Height: _____ Weight: _____

Address: _____ City:_____ State_____ Zip:_____

Phone: _____ Email: _____

Primary Care Physican: _____

Date of last General Physical Exam: _____

OB/GYN:_____ Have you seen this practicioner within the last year? YES NO

Is either physician aware of your interest in BHRT? YES NO

Your current medical conditions or diagnoses: _____

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MEDICATION HISTORY

Names of ALL prescription medications taken in the last 6 months. *(Include strength and how you take them)*

Medication	**Strength**	**Start Date**	**How Prescribed**

Names of **ALL** Vitamins, Supplements, Non-Prescription medicines or other OTC products that you are currently using:

_____

_____

_____

Please list any and all medications or supplements used to alleviate hormone related symptoms:

Medication/Herbal Supplement	**Strength**	**Start Date**	**End Date**	**Reason for discontinuation:**

Drug Allergies: _____

Allergies to food, pollen, environment, etc.: _____

Do you use tobacco products: YES NO If yes, what? _____ How much? _____ How long? _____

Do you use alcohol products: YES NO If yes, what? _____ How much? _____ How long? _____

Do you use caffeine products: YES NO If yes, what? _____ How much? _____ How long? _____

How much water do you drink per day (24 hour)? _____oz. per day

Dietary restrictions (such as salt, carbohydrates, milk products, red meat, etc.)

_____

_____

_____

REPRODUCTIVE HEALTH/HISTORY

Date of last General Physical Exam: _____

Date of last Pelvic Exam: _____

Have you ever had an abnormal pap? YES NO Date: _____

At what age was your first menstrual period: _____

When was your most recent or last menstrual period? _____

How many days from the start of one period to the start of the next? _____ days

Number of days of flow: _____ Amount of bleeding: _____

Describe any cramping or pain you may have: _____

Any current changes in your normal cycle? _____

If your periods have ever been difficult, irregular, or abnormal in any way, please describe:

_____

_____

Have you ever had any of the following surgeries:

Tubal ligation (tubes tied)? YES NO If so, When? _____ At what age? _____

Uterus removed (hysterectomy)? YES NO If so, When? _____ At what age? _____

Ovaries removed (oophorectomy)? YES NO If so, When? _____ At what age? _____

Where there any problems associated with the surgery or removal of any of these organs? _____

Have you ever been pregnant? YES NO Are you trying to get pregnant? YES NO

What was the age of your first pregnancy? _____ Number of pregnancies _____

Received any infertility treatment to aid in conception? _____ If so, what methods?_____

Any interrupted pregnancies (miscarriage or abortions)? YES NO

Current birth control method: _____

How long? _____ Any problems? _____

Have you ever used any of the following birth control methods:

Oral Contraceptives (Birth Control Pills): YES NO Total months / years used: _____

Any side effects to Birth Control Pills: _____

Intra-Uterine Device (IUD): YES NO Problems: _____

BREAST HEALTH/HISTORY

Date of last mammogram? _____ Results:_____

Do you examine your breast monthly? YES NO

Have you ever experienced breast pain, discomfort, nipple discharge, or swelling other than when pregnant? Please give details:

_____

_____

_____

Have you ever been diagnosed with lumps, fibroids, breast cancer, or similar breast condition?

_____

_____

If your doctor has recently ordered lab tests or diagnostic procedures for you, please give details including whether the test or procedure was performed and the results:

_____

_____

_____

GENERAL QUESTIONS AND CONCERNS

Please list and all questions and concerns that you may have regarding BioIdentical Hormones or your symptoms

_____

_____

_____

_____

_____

_____

_____

_____

_____

SYMPTOMS

	SEVERE	MODERATE	MILD	NON-EXISTENT
Hot Flashes	☐	☐	☐	☐
Night Sweats	☐	☐	☐	☐
Headaches	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐
Irritability	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐
Mood Swings	☐	☐	☐	☐
Confusion/Foggy Thinking	☐	☐	☐	☐
Difficulty Concentrating	☐	☐	☐	☐
Forgetfulness	☐	☐	☐	☐
Angry outbursts	☐	☐	☐	☐
Crying easily	☐	☐	☐	☐
Joint pains	☐	☐	☐	☐
Muscle pains	☐	☐	☐	☐
Muscle cramps / spasms	☐	☐	☐	☐
Problems with wound healing times	☐	☐	☐	☐
Acne	☐	☐	☐	☐
Dry skin / Dry Hair	☐	☐	☐	☐
Hair Loss	☐	☐	☐	☐

	SEVERE	MODERATE	MILD	NON-EXISTENT
Frequent Urinary Tract Infections (UTI)	☐	☐	☐	☐
Urinary frequency/incontinence	☐	☐	☐	☐
Vaginal dryness	☐	☐	☐	☐
Abnormal bleeding	☐	☐	☐	☐
Painful intercourse	☐	☐	☐	☐
Loss of sexual feeling / desire	☐	☐	☐	☐
Loss of arousability & capacity for orgasm	☐	☐	☐	☐
Loss of sexual sensitivity	☐	☐	☐	☐
Loss of vitality	☐	☐	☐	☐
Nipple sensitivity	☐	☐	☐	☐
Discharge or leaking from nipples	☐	☐	☐	☐
Breast tenderness	☐	☐	☐	☐
Loss of pubic hair	☐	☐	☐	☐
Swelling	☐	☐	☐	☐
Heart palpitations	☐	☐	☐	☐
Shortness of breath	☐	☐	☐	☐
Food/sweets/salt cravings	☐	☐	☐	☐
Increased appetite	☐	☐	☐	☐
Weight gain	☐	☐	☐	☐