Tahlequah Drug Compounding

Phone 918 431 0555

Fax 918 431 0316 2028 Mahaney Ave Tahlequah, Ok 74464



Women's Health & Wellness

pharmacy@tahlequahdrugeo.com

www.tahlequahdrugeo.com

TODAY'S DATE /	/	BIRTHDATE / /	AGE		
NAME		HEIGHT	WEIGHT		
ADDRESS:		DO YOU USE TOBACCO? YES NO HOW OFTEN, HOW MUCH?			
CITY STATE ZIP CODE		DO YOU USE ALCOHOL? YES NO HOW OFTEN, HOW MUCH?			
		DO NOW HOLD ON DEPONDED AND A NO	DO YOU USE CAFFEINE? YES NO HOW OFTEN, HOW MUCH?		
PHONE	PHONE				
EMAIL					
DOCTOR'S NAME	PHONE	OFFICE ADDRESS			
ALLERGIES (PLEASE CHE	CCK ALL THAT APPLY TO YOU.)				
[] Penicillin		[] No Known Allergies [] Other: [] Pet Allergies [] Seasonal (pollen) Allergies			
PLEASE DESCRIBE TH	HE REACTION YOU EXPERIENCE	ED AND WHEN IN OCCURRED:			

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Pharmacists Shanon Gower & Jana Evensen

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OVER-THE-COUNTER ISSUES (PLEASE CHECK ALL THAT A	PPLY TO YOU.)				
[] Aspirin [] Acetaminophen (ex: Tylenol®) [] Ibuprofen (ex: Advil® or Motrin IB®) [] Naproxen (ex: Aleve®) [] Cough suppressant (ex: Robitussin DM®) [] Antihistamine (ex: Chlor-Trimeton®) [] Decongestant (ex: Sudafed®) [] Vitamins or Herbs:	[] Combination [] Sleep aids (ex: [] Antidiarrheals [] Laxatives/stoo [] Diet aids/weig [] Antacids (ex: [] Acid blockers [] Others:	Exedrin PM [®] , Un (ex: Imodium [®] , Pe ol softeners (ex: Co ght loss products (Maalox [®] , Mylanta [®] (ex: Tagamet HB [®]	olace [®] , Correctol [®]) ex: Dexatril [®])		
[] Cancer	[] Epilepsy				
[] Ulcers (stomach, esophagus)	[] Headache/mig				
[] Thyroid disease [] Hormonal related items	=	[] Eye disease (ex: Glaucoma, etc.)			
[] Lung conditions (ex: asthma, emphysema, COPD)	[] Others:	[] Others:			
[] Blood clotting problems					
CURRENT PRESCRIPTION MEDICATIONS:					
MEDICATION NAME	STRENGTH	DATE STARTED	HOW OFTEN PER DAY		
		-			
LIST HORMONES PREVIOUSLY TAKEN:					
		·····			

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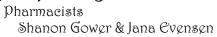
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HAVE YOU EVER USED ORAL CONTRACEPTIVES? YES NO ANY PROBLEMS? YES NO IF YES, PLEASE DESCRIBE:				
II TEG, I BENGE DECCREDE.				
HOW MANY PREGNANCIES HAVE YOU HAD?	HOW MANY CHILDREN?			
ANY INTERRUPTED PREGNANCIES? YES NO	<u></u>			
HAVE YOU HAD A HYSTERECTOMY? YES NO / DATE OF SURG	ery: / /			
HAVE YOU HAD YOUR OVARIES REMOVED? YES NO				
HAVE YOU HAD TUBAL LITIGATION? YES NO / DATE OF SURG	ZERY: / /			
DO YOU HAVE A FAMILY HISTORY OF THE FOLLO	OWING:			
[] Uterine cancer / Family member:	[] Breast cancer / Family member:			
[] Ovarian cancer / Family member:	[] Heart disease / Family member:			
[] Fibrocystic breast / Family member:	[] Osteoporosis / Family member:			
HAVE YOU HAD EITHER OF THE FOLLOWING TES	ST DERECRMED.			
MAMMOGRAPHY? YES NO / DATE:	PAP SMEAR? YES NO / DATE:			
SINCE YOU FIRST BEGAN HAVING PERIODS, HAVE YOU EVER HAD W	HAT YOU WOULD CONSIDER TO BE ABNORMAL CYCLES? YES NO			
IF YES, PLEASE EXPLAIN (AGE, SYMPTOMS, DATES, ETC.)				
WHEN WAS YOUR LAST PERIOD?	HOW MANY DAYS DID IT LAST?			
DO YOU, OR DID YOU EVER, HAVE PREMENSTRUAL SYNDROME (PMS)? YES NO			
IF YES, PLEASE EXPLAIN (AGE, SYMPTOMS, DATES, ETC.)				

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PATIENT INFORMATION SHEET

	ABSENT	MILD	MODERATE	SEVERE	COMMENT
	1	2	3	4	
Fibrocystic breast					
Weight gain					
Heavy / irregular mensus					
Hot flashes					
Dry skin / hαir					
Anxiety					
Depression					
Night sweats					
Vaginal dryness					
Headaches					
Irritαbility					
Mood swings					
Breast tenderness					
Sleep disturbances / insomnia					
Cramps					
Fluid retention					
Breakthrough bleeding					
Fatigue					
Loss of memory					
Bladder symptoms					
Arthritis					
Harder to reach climax					
Decreased sex drive					
Hair loss					
Facial hair					

WHAT ARE YOUR GOALS WITH TAKING BHRT?	PLEASE WRITE ANY QUESTIONS YOU MAY HAVE: