# Tahlequah Drug Compounding

Pharmacists
Shanon Gower & Jana Evensen

Phone 918 431 0555

Fax 918 431 0316
2028 Mahaney Ave
Tahlequah, Ok 74464

## Women's Health & Wellness

pharmacy@tahlequahdrugco.com www.tahlequahdrugco.com


TODAY'S DATE / /

BIRTHDATE / / AGE

NAME

HEIGHT WEIGHT

ADDRESS:

DO YOU USE TOBACCO? YES NO
HOW OFTEN, HOW MUCH?

CITY

DO YOU USE ALCOHOL? YES NO
HOW OFTEN, HOW MUCH?

STATE ZIP CODE

DO YOU USE CAFFEINE? YES NO
HOW OFTEN, HOW MUCH?

PHONE

EMAIL

| DOCTOR'S NAME | PHONE | OFFICE ADDRESS |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**ALLERGIES** (PLEASE CHECK ALL THAT APPLY TO YOU.)

[ ] Penicillin
[ ] Codeine
[ ] Sulfa Drug
[ ] Morphine
[ ] Aspirin
[ ] Food Allergies
[ ] Dye Allergies
[ ] Nitrate Allergy
[ ] No Known Allergies
[ ] Pet Allergies
[ ] Seasonal (pollen) Allergies
[ ] Other:

**PLEASE DESCRIBE THE REACTION YOU EXPERIENCED AND WHEN IN OCCURRED:**

BIO-IDENTICAL HORMONE EVALUATION

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## OVER-THE-COUNTER ISSUES (PLEASE CHECK ALL THAT APPLY 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 (cough + cold releiver/ex: Triminc DM®)
[ ] Sleep aids (ex: Exedrin PM®, Unisom, Sominex®, Nytol®)
[ ] Antidiarrheals (ex: Imodium®, Pepto Bismol®)
[ ] Laxatives/stool softeners (ex: Colace®, Correctol®)
[ ] Diet aids/weight loss products (ex: Dexatril®)
[ ] Antacids (ex: Maalox®, Mylanta®)
[ ] Acid blockers (ex: Tagamet HB®, Pepcid C®, Prilosec®)
[ ] Others : .....
.....

## MEDICAL CONDITIONS/DISEASES (PLEASE CHECK ALL THAT APPLY TO YOU.)

[ ] Heart disease (ex: Congestive Heart Failure)
[ ] High cholesterol or lipids (ex: Hyperlipidemia)
[ ] High blood pressure (ex: Hypertension)
[ ] Cancer
[ ] Ulcers (stomach, esophagus)
[ ] Thyroid disease
[ ] Hormonal related items
[ ] Lung conditions (ex: asthma, emphysema, COPD)
[ ] Blood clotting problems

[ ] Diabetes
[ ] Arthritis or joint problems
[ ] Depression
[ ] Epilepsy
[ ] Headache/migraines
[ ] Eye disease (ex: Glaucoma, etc.)
[ ] Others:

## CURRENT PRESCRIPTION MEDICATIONS:

| MEDICATION NAME | STRENGTH | DATE STARTED | HOW OFTEN PER DAY |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
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## 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:

HOW MANY PREGNANCIES HAVE YOU HAD? HOW MANY CHILDREN?

ANY INTERRUPTED PREGNANCIES? YES NO

HAVE YOU HAD A HYSTERECTOMY? YES NO / DATE OF SURGERY: / /

HAVE YOU HAD YOUR OVARIES REMOVED? YES NO

HAVE YOU HAD TUBAL LITIGATION? YES NO / DATE OF SURGERY: / /

## DO YOU HAVE A FAMILY HISTORY OF THE FOLLOWING:

[ ] Uterine cancer / Family member:

[ ] Ovarian cancer / Family member:

[ ] Fibrocystic breast / Family member:

[ ] Breast cancer / Family member:

[ ] Heart disease / Family member:

[ ] Osteoporosis / Family member:

## HAVE YOU HAD EITHER OF THE FOLLOWING TEST PERFORMED:

MAMMOGRAPHY? YES NO / DATE:

PAP SMEAR? YES NO / DATE:

SINCE YOU FIRST BEGAN HAVING PERIODS, HAVE YOU EVER HAD WHAT 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 1 | MILD 2 | MODERATE 3 | SEVERE 4 | COMMENT |
|---|---|---|---|---|---|
| Fibrocystic breast | | | | | |
| Weight gain | | | | | |
| Heavy / irregular mensus | | | | | |
| Hot flashes | | | | | |
| Dry skin / hair | | | | | |
| Anxiety | | | | | |
| Depression | | | | | |
| Night sweats | | | | | |
| Vaginal dryness | | | | | |
| Headaches | | | | | |
| Irritability | | | | | |
| 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:**

BIO-IDENTICAL HORMONE EVALUATION