Safeway Compounding Pharmacy
6100 Hellyer Avenue #100, San Jose, CA 95138
Phone (408)227-1098 * Fax (408)227-1206

PATIENT INFORMATION AND HEALTH SUMMARY

Name Date

Address

Phone Date of Birth Height Weight

Email Address (for contact purpose only)

Occupation: Full Time? ☐ Part Time? ☐ Retired? ☐

Do You Drink Alcohol? ☐ Y ☐ N How frequently?_____

Do You Smoke? ☐ Y ☐ N If yes, how many cigarettes per day?_____

Do You Exercise? ☐ Y ☐ N Type?_____ How often?_____

Caffeine Consumption ☐ Y ☐ N Type (coffee, soda)_____ How often?_____

Describe Your Diet**:**

Breakfast:

Lunch:

Dinner:

Snacks:

Current Prescription Medications:

Non-prescription Medications &/or Vitamins/Herbal Supplements:

NATURAL HORMONE REPLACEMENT CONSULTATION/ASSESSMENT INFORMATION

Current Medical Diagnosis or condition (s):

_____

_____

_____

Past Medical Conditions (Check any that apply)

- ☐ Asthma
- ☐ Cancer (type _____)
- ☐ Depression
- ☐ Diabetes
- ☐ Headaches/Migraine
- ☐ High Blood Pressure
- ☐ Osteoporosis/Osteopenia
- ☐ Fractures
- ☐ Epilepsy
- ☐ Liver Disorder
- ☐ Fibromyalgia
- ☐ Arthritis
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Thyroid Issues
- ☐ Clotting Disorder
- ☐ Gallbladder Disease
- ☐ Eating Disorder
- ☐ Chronic Fatigue Syndrome
- ☐ Other_____

Family History (Check all that apply)

- ☐ Cancer (Type_____)
- ☐ Diabetes (Type_____)
- ☐ Osteoporosis
- ☐ Heart Disease
- ☐ Alzheimer's Disease
- ☐ Other_____

OBSTETRICAL HISTORY

Are you sexually active? ☐ Y ☐ N

Are you trying to get pregnant? ☐ Y ☐ N

Current Method of birth control _____

Have you taken Birth Control Pills, either now ☐ or in the past? ☐ How long? _____

Any side effects while on Birth Control Pills?_____

Have you had children? ☐ Y ☐ N Number of pregnancies:____ Number of deliveries:____

GYNECOLOGICAL HISTORY

Are you: ☐ Pre-Menopausal ☐ Peri-Menopausal ☐ Post-Menopausal ☐ Not sure

Date of your last period? _____

Have you had a hysterectomy? ☐ Y ☐ N When_____

Have you had any part or whole ovary removed? ☐ Y ☐ N

If YES: One Ovary removed ☐ Both Ovaries removed ☐ When_____

Have you every had an abnormal pap? ☐ Y ☐ N

Check any of the following problems you may have had:

☐ Sexual Problems	☐ Increased facial/body hair	☐ Uterine fibroids	☐ Lack of energy
☐ Lack of sex drive	☐ Vaginal infections	☐ Loss of pubic hair	☐ Breast fibroids
☐ Painful intercourse	☐ Inability to reach climax	☐ Cervical dysplasia	☐ Thinning hair
☐ Vaginal Dryness	☐ Ovarian cysts	☐ Pelvic Infections	☐ Cervical Cancer

MENSTRUAL HISTORY

As a teenager were your periods: ☐ Regular ☐ Irregular ☐ Spotting ☐ Light ☐ Heavy

PMS: ☐ Sometimes ☐ Severe ☐ Each time ☐ Did not notice

Presently: ☐ Regular ☐ Irregular ☐ Light ☐ Heavy ☐ No periods

Have you missed periods altogether? ☐ Y ☐ N When was your last period?_____

Number of days of cycle (from day 1 of period to day 1 of next period): _____

Do you have bleeding between periods? ☐ Y ☐ N

When was your last: Pap Smear?_____ Bone Density_____ Cholesterol _____

Hormone Panel_____ Mammogram_____ Thyroid Panel _____

Have you ever taken hormones (synthetic or natural) before? ☐ Y ☐ N

If yes, please list medications, doses, and any side effects here:

_____

_____

_____

MENSTRUAL HISTORY (CONT.)

Have you tried alternative therapies or taken herbal or homeopathic products? ☐ Y ☐ N

If so, please list them here:

How did you become interested in Natural Hormone Replacement Therapy?

Check symptoms of low Progesterone:

- ☐ Headaches
- ☐ Anxiety
- ☐ Depression
- ☐ Irritability
- ☐ Food Cravings
- ☐ PMS symptoms
- ☐ Painful Breasts
- ☐ Painful Joints
- ☐ Insomnia
- ☐ Low Sex Drive
- ☐ Moodiness
- ☐ Swollen Breasts
- ☐ Fuzzy Thinking
- ☐ Water Retention
- ☐ Cramps
- ☐ Weight Gain
- ☐ Inability to Concentrate
- ☐ Hair Loss
- ☐ Painful Breasts

Check symptoms of low Estrogen:

- ☐ Hot Flashes
- ☐ Heart Palpitations
- ☐ Mood Swings
- ☐ Depression
- ☐ Vaginal Dryness
- ☐ Night Sweats
- ☐ Sleep Disorder
- ☐ Dry Hair
- ☐ Dry Skin
- ☐ Shortness of Breath
- ☐ Urinary Infections
- ☐ Yeast Infections
- ☐ Short Term Memory Loss
- ☐ Painful Intercourse

STRESS RESPONSE SYSTEM QUESTIONNAIRE B

Consider each questions carefully, then answer yes or no to indicate how well the question describes you.

Do you frequently feel cold? ☐ Y ☐ N

Do you experience symptoms of PMS? ☐ Y ☐ N
(breast tenderness, abdominal cramps, heavy periods, mood swings)

Do you suffer from insomnia? ☐ Y ☐ N

Do you have low blood pressure? ☐ Y ☐ N

Do you frequently get irritable? ☐ Y ☐ N

Do you have poor memory or concentration? ☐ Y ☐ N

Do you notice palpitations? ☐ Y ☐ N

Do you get frequent/chronic infections? ☐ Y ☐ N

Do you have dry, thinning skin? ☐ Y ☐ N

Do you get headaches? ☐ Y ☐ N

Do you have unexplained hair loss? ☐ Y ☐ N

Do you skip meals? ☐ Y ☐ N

Do you exercise less than twice a week? ☐ Y ☐ N

Do you have thyroid problems? ☐ Y ☐ N

Do you lack energy during the day? ☐ Y ☐ N

Do you need caffeine in the morning or after lunch? ☐ Y ☐ N

Are you emotionally overstressed? ☐ Y ☐ N

Do you suffer from depression or down moods? ☐ Y ☐ N

Do you experience a “second wind” (high energy) at bedtime? ☐ Y ☐ N

Do you suffer from low blood sugar/hypoglycemia? ☐ Y ☐ N
(i.e. headaches, sleepiness, mood swings if skipping meals)

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RELEASE AUTHORIZATION

☐ I hereby release my Physician to furnish an agent of Safeway Compounding Pharmacy any and all records pertaining to my medical history, services rendered, and/or treatments.

☐ I authorize my Pharmacist to release my personal medication and/or other medical information to my Physician(s) upon request or as deemed necessary.

☐ I understand that employees of Safeway Compounding Pharmacy will protect my privacy and this information will be released to other health care professionals only when necessary in order to provide health care services to me. This authority shall continue until revoked by me in writing.

Physician Name (Last, First)

Phone

Physician Name (Last, First)

Phone

Physician Name (Last, First)

Phone

Patient Name:

Address

City, State, Zip

Phone

Email

Signature Date