CENTRAL COMPOUNDING CENTER

Female Consultation Health Questionnaire

Please complete and bring with you to your appointment. Please bring **ALL** of your medications, vitamins, nutritional supplements, herbals, etc. that you are taking to your appointment.

Today's Date____________

How did you hear about our consultative services?_________________________

Patient Information

Name____

Address____

City__________________________________ State________ Zip____________

Home Phone______________________ Work Phone______________________

Email address ____

Birthdate _____________ Height_____________ Weight______________

Lifestyle Information

	Do You Use?	If yes, how often and how much?
Tobacco	□ Yes □ No	
Alcohol	□ Yes □ No	
Caffeine-Cola drinks, tea, coffee?	□ Yes □ No	
Do you exercise regularly?	□ Yes □ No	
Do you practice any stress management techniques?	□ Yes □ No	

Health Care Provider Information

Are you currently under the care of a physician? □ Yes □ No
If yes, please list each doctor from whom you seek care, including address and phone number.

Provider Name:____

Address:____________________________________Phone:____________

Provider Name:____

Address:____________________________________Phone:____________

Allergies

Please list and describe any allergies that you have to medications/foods/etc:

____

____

____

Medications (Prescription/Over-the-Counter) & Nutritional Supplements

Please list ALL medications (prescriptions, over-the-counter, vitamins, supplements, herbals, etc), which you take regularly and as needed. Please list the dose as well. If you need additional space, use the back of this page.

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____

9. ____

10. ____

11. ____

12. ____

Dietary Information

How many times do you eat out during a week (7 days)? ________________

Are there any foods you crave? ☐ Yes ☐ No If yes, please list below.

____

____

Please describe your typical eating patterns:

Breakfast:____

____

Lunch:____

____

Dinner:____

____

Snacks:____

____

How much water do you drink daily?_____________________________

What is the source of water? ☐ Bottled water ☐ Well water

☐ City water ☐ Filtered

Medical Conditions/Diseases

Please list any diagnosed medical conditions that you have and approximate date of diagnosis. If you need additional space, use the back of this page.

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________

Family Medical History

Father (Living/Deceased) Age____

Medical History______________________________

Mother(Living/Deceased) Age____

Medical History______________________________

Brother/Sister(Living/Deceased) Age____

Medical History______________________________

Brother/Sister(Living/Deceased) Age____

Medical History______________________________

Brother/Sister(Living/Deceased) Age____

Medical History______________________________

Brother/Sister(Living/Deceased) Age____

Medical History______________________________

Gynecological History

Are you: □ Pre-menopausal □ Peri-menopausal □ Post-menopausal?

Age at first period____________

What was the approximate date of your last period____________________

Date of last pelvic exam/pap smear__________Results?_____________________

Have you ever had an abnormal pap?_____ Treatment?______________________

Are you sexually active? □ Yes □ No

Are you trying to get pregnant? (if applicable) ____________

Current birth control method (if applicable) ________________________

Problems with birth control in the past? (if applicable) □ Yes □ No

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

Number of Days of Flow?________ Amount of Bleeding?____________________

Any Current changes in your normal cycle?_________________________

Do you have any bleeding between periods? □ Yes □ No

Do you have any pelvic pain? □ Yes □ No Please describe:_________________

____

Do you have any unusual vaginal discharge or itching? □ Yes □ No Please describe: ____

Age at first pregnancy? (if applicable)_________

How many full term pregnancies? (if applicable)______

How many interrupted pregnancies?_______________________________________

Have you had a tubal ligation? □ Yes □ No When?________________

Have you had a hysterectomy? □ Yes □ No Partial or Complete Date__________

List and Explanation of Symptoms

Have you experienced any of the following symptoms recently? Please circle the number that best describes your experiences, with 1 being Extremely Mild and 10 being Extremely Severe.

Anxiety 1 2 3 4 5 6 7 8 9 10
Describe ____

Bloating 1 2 3 4 5 6 7 8 9 10
Describe ____

Breast tenderness 1 2 3 4 5 6 7 8 9 10
Describe ____

Constipation 1 2 3 4 5 6 7 8 9 10
Describe ____

Cramps 1 2 3 4 5 6 7 8 9 10
Describe ____

Depression 1 2 3 4 5 6 7 8 9 10
Describe ____

Dry Hair/Skin 1 2 3 4 5 6 7 8 9 10
Describe ____

Emotional Swings 1 2 3 4 5 6 7 8 9 10
Describe ____

Fatigue 1 2 3 4 5 6 7 8 9 10
Describe ____

Fibrocystic Breast 1 2 3 4 5 6 7 8 9 10
Describe ____

Fibroids 1 2 3 4 5 6 7 8 9 10
Describe ____

Fuzzy Thinking 1 2 3 4 5 6 7 8 9 10
Describe ____

Headaches 1 2 3 4 5 6 7 8 9 10
Describe____

Heart Palpitations 1 2 3 4 5 6 7 8 9 10
Describe ____

Heavy Menses 1 2 3 4 5 6 7 8 9 10
Describe ____

Hot Flashes 1 2 3 4 5 6 7 8 9 10
Describe ____

Insomnia 1 2 3 4 5 6 7 8 9 10
Describe ____

Irregular Menses 1 2 3 4 5 6 7 8 9 10
Describe ____

Irritability 1 2 3 4 5 6 7 8 9 10
Describe ____

Low Concentration 1 2 3 4 5 6 7 8 9 10
Describe ____

Low Libido 1 2 3 4 5 6 7 8 9 10
Describe ____

Low Thyroid 1 2 3 4 5 6 7 8 9 10
Describe ____

Memory Loss 1 2 3 4 5 6 7 8 9 10
Describe ____

Moodiness 1 2 3 4 5 6 7 8 9 10
Describe ____

No Orgasm 1 2 3 4 5 6 7 8 9 10
Describe ____

Overwhelmed 1 2 3 4 5 6 7 8 9 10
Describe ____

Painful Intercourse 1 2 3 4 5 6 7 8 9 10
Describe ____

Slow recovery from illness 1 2 3 4 5 6 7 8 9 10
Describe ____

Stress 1 2 3 4 5 6 7 8 9 10
Describe ____

Urinary Infections 1 2 3 4 5 6 7 8 9 10
Describe ____

Vaginal Dryness 1 2 3 4 5 6 7 8 9 10
Describe ____

Water Retention 1 2 3 4 5 6 7 8 9 10
Describe ____

Weight Gain 1 2 3 4 5 6 7 8 9 10
Describe ____

Yeast Infections 1 2 3 4 5 6 7 8 9 10
Describe ____

Other 1 2 3 4 5 6 7 8 9 10
Describe ____

Other 1 2 3 4 5 6 7 8 9 10
Describe ____

Please write down any issues/questions you wish to discuss with the Pharmacist in advance so that we make sure to cover all of your concerns.

The information I have provided is correct to the best of my knowledge. In the course of making recommendations to your health care provider, we will share any pertinent labs that we may have. I authorize you (Pharmacist) to have access to labs or medical records from my other health care providers if needed to help develop recommendations.

Printed Name____

Signature____ Date____________

Pharmacist's Notes

Consultation #1   Date_____________________

Subject/Objective

Assessment/Plan

Consultation #2   Date__________________________

Subjective/Objective

Assessment/Plan

Consultation #3   Date______________________________

Subjective/Objective

Assessment/Plan