PHARMACY COMPOUNDING SOLUTIONS
(FEMALE PACKET)

LYNN IRWIN SALLANDER - COMPOUNDING PHARMACIST
2310 MILDRED STREET WEST SUITE 138
UNIVERSITY PLACE, WA 98466
253.564.2323 PH / 253.564.3131 FAX

PATIENT INFORMATION AND HEALTH SUMMARY

Please complete the following confidential information and return to Pharmacy Compounding Solutions

Name ____/____________________________/_____________
Last First M.I.

Address____________________________________/__________________/_______/__________________
Street City State Zip Code

Phone (____)____________________Sex ☐Male ☐ Female WA Drivers License___________________

Date of Birth ____/____/______ E-mail Address ____

Person responsible for the account __________________________ Social Security Number_____________

Employer______________________ Phone (____)____________ Job Title __________________________

Business Address _______________________________ City _________________ State _____ Zip ________

Person to contact in the event of an emergency ____

Relationship ______________________________ Telephone (____)___________________________

Who referred you to us? ____

AUTHORIZATION FOR TREATMENT

I, the undersigned, hereby authorize the physician/pharmacist to perform diagnostic tests deemed necessary for my care and to perform any and all forms of treatment, medication, and therapy that are indicated and are in accordance with the Standards of Care. I furthermore agree to use Pharmacy Compounding Solutions for all compounded prescriptions that I choose to fill the compounding pharmacist at PCS has consulted with me on. Failure to use Pharmacy Compounding Solutions will result in a consultation fee of $150.00 per consult. Furthermore, I understand that Pharmacy Compounding Solutions does not accept insurance. Payment is due at the time of appointment or pick up of medications. I understand I am responsible for billing my insurance company.

PATIENT SIGNATURE_______________________________________ DATE____/____/____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much and how often? ___________________________
Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? _________________________________
Do you exercise? ☐ Yes ☐ No If yes, what type and how often? _________________________________
Do you consume caffeine? ☐ Yes ☐ No If yes, what type and how often? ________________________
Please describe your diet: ____

____

Do you want child-resistant tops on your prescription containers? ☐ Yes ☐ No

MEDICAL HISTORY

Your Past/Current Medical Conditions	Family Members Past/Current Medical Conditions
☐ Alcoholism	☐ Alcoholism: Who? ____________________________
☐ Alzheimer's	☐ Alzheimer's: Who? ___________________________
☐ Anemia	☐ Anemia: Who? _______________________________
☐ Arthritis (Type:_______________________________)	☐ Arthritis (Type:____________)Who?_____________
☐ Benign Prostatic Hyperplasia	☐ Benign Prostatic Hyperplasia: Who? ______________
☐ Blood Clots (Type:_____________________________)	☐ Blood Clots: (Type:__________) Who?___________
☐ Blood Disorders (Type:_________________________)	☐ Blood Disorders (Type:_________) Who?_________
☐ Cancer (Type:_________________________________)	☐ Cancer (Type:_______________) Who? __________
☐ Chronic Fatigue Syndrome	☐ Chronic Fatigue Syndrome: _____________________
☐ Clotting Disorder	☐ Clotting Disorder: Who? _______________________
☐ Depression	☐ Depression: ________________________________
☐ Diabetes (Type:_______________________________)	☐ Diabetes: (Type:___________) Who?____________
☐ Drug Addiction	☐ Drug Addiction: Who? _________________________
☐ Eating Disorder	☐ Eating Disorder: Who? _________________________
☐ Eczema	☐ Eczema: Who? _______________________________
☐ Erectile Dysfunction	☐ Erectile Dysfunction: Who? ____________________
☐ Epilepsy	☐ Epilepsy: Who? ______________________________
☐ Fibromyalgia	☐ Fibromyalgia: Who? ___________________________
☐ Fractures	☐ Fractures: Who? _____________________________
☐ Gallbladder Disease	☐ Gallbladder Disease: Who ______________________
☐ Gout	☐ Gout: Who? _________________________________
☐ Headaches/Migraines	☐ Headaches/Migraines: Who? ____________________
☐ Heart Disease (Type:_________________________)	☐ Heart Disease: (Type:___________) Who?________
☐ Hepatitis (Type: ______________________________)	☐ Hepatitis (Type:_______________) Who?_________
☐ High Blood Pressure	☐ High Blood Pressure: Who? _____________________
☐ High Cholesterol	☐ High Cholesterol: Who? ________________________
☐ HIV+	☐ HIV+: Who? __________________________________
☐ Insomnia	☐ Insomnia: Who? ______________________________
☐ Kidney Disorder	☐ Kidney Disorder: Who? _________________________
☐ Liver Disorder (Type: __________________________)	☐ Liver Disorder: Who? __________________________
☐ Lung Disorder (Type:___________________________)	☐ Lung Disorder: (Type:____________)Who?________
☐ Mental Illness (Type: __________________________)	☐ Mental Illness: (Type:____________)Who?________
☐ Migraines	☐ Migraines: Who? ______________________________
☐ Osteoporosis	☐ Osteoporosis: Who? ___________________________
☐ Psoriasis	☐ Psoriasis: Who? ______________________________
☐ Seizures (Type:________________________________)	☐ Seizures (Type: _____________)Who?___________
☐ Stroke	☐ Stroke: Who? ________________________________
☐ Suicidal Thoughts or Attempts	☐ Suicidal Thoughts or Attempts: Who? ____________
☐ Thyroid Disorder	☐ Thyroid Disorder: Who? ________________________
☐ Other:_____________________________________ _____________________________________	☐ Other Conditions(Type:________________________) Who?______________________________________

Are you currently on any prescription or non-prescription medication/supplements? ☐ Yes ☐ No

If yes, please list the medication and/or supplements on the lines below:

Medication/Supplement Strength Directions for use Reason for use Date Started

1. ______
2. ______
3. ______
4. ______
5. ______
6. ______
7. ______
8. ______
9. ______

List any medications or supplements which you are allergic to and describe the reaction.

1. ______
2. ______
3. ______
4. ______
5. ______

Please list any food or other allergies you have: ______

______

Are you chemically and/or environmentally sensitive? ☐ Yes ☐ No

Have you ever taken hormones (synthetic or natural) before? ☐ Yes ☐ No

If yes, please list the hormone medication(s) you have used on the lines below:

	Drug Name	Strength	When Used	Side Effects	Benefits
1					
2					
3					
4					
5					

If you discontinued the use of hormones, please briefly explain why. Additionally, please explain why you are seeking bio-identical hormone replacement therapy (HRT).

______

______

Have you tried any alternative therapies or taken any herbal or homeopathic products?

☐ Yes ☐ No If yes, please list them here: ______

______

MENSTRUAL HISTORY

1. PMS, or premenstrual syndrome, is defined as a condition in which a variety of symptoms may occur during the 7 to 14 days before a menstrual period begins. Please check any symptoms you currently experience or have experienced in the past from the list below:

   ☐ Mild physiological discomfort ☐ Bloating ☐ Weight gain
   ☐ Swelling of hands and feet ☐ Breast tenderness ☐ Aches and pains
   ☐ Poor concentration ☐ Sleep disturbances ☐ Change in appetite

   How would you describe your PMS in the past?
   ☐ Didn't notice ☐ Sometimes ☐ Each time ☐ Severe
   Do you currently suffer from PMS? ☐ Yes ☐ No If yes, what time of the month?_________________
   As you have aged, has your PMS worsened? ☐ Yes ☐ No
   Please describe what you have noticed triggers your PMS:_______________________________________

   ____

2. Describe your menstrual periods presently (check all that apply):

   ☐ Regular ☐ Light ☐ Sporadic ☐ Brown Blood
   ☐ Irregular ☐ Heavy ☐ No periods ☐ Bright Red Blood
   ☐ Clotty ☐ Premenstrual spotting (≥3 days) ☐ Postmenstrual Spotting (≥3 days)

3. Have you ever had cramping or pain with your period? ☐ Yes ☐ No

4. Have you ever skipped periods all together? ☐ Yes ☐ No

5. When was your last menstrual period?_______________ How long is your cycle?_____days

6. Do you have any bleeding between periods? ☐ Yes ☐ No When?_____________________

7. When was your last test:

   - Pap smear ______________
   - Bone Density _______________
   - Cholesterol _____________
   - Hormone Panel______________
   - Mammogram ____________
   - Thyroid Panel _______________

OBSTETRICAL HISTORY

1. Are you sexually active? ☐ Yes ☐ No If yes, please check how frequently you have sex below:
   ☐ Rarely ☐ Sometimes ☐ Often
   Are you satisfied with this level of sexual activity? ☐ Yes ☐ No
2. Are you trying to get pregnant? ☐ Yes ☐ No
3. Current method of birth control? ________________________ How long? ___________________
4. Past birth control and any related problems? ____
5. Have you ever had children? ☐ Yes ☐ No
6. Number of: pregnancies_______ deliveries________ miscarriages________

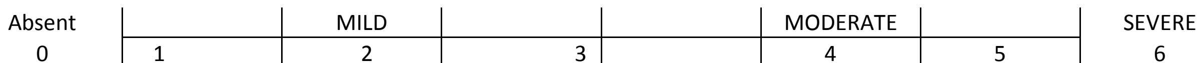
GYNECOLOGICAL HISTORY

1. Have you had a hysterectomy? ☐ Yes ☐ No If yes, when?________________________________
2. Have you had any part of or your whole ovary removed? ☐ Yes ☐ No If yes, when?____________
3. Have you ever had a tubal ligation? ☐ Yes ☐ No If yes, when? ____________________________
4. Have you ever had an abnormal pap? ☐ Yes ☐ No
   If yes, what was the abnormality and how was it treated?____________________________________
   ____
5. Please check any of the following conditions you have had in the past or currently have:

   ☐ HSV (vaginal herpes) ☐ Cervical cancer ☐ Uterine fibroids
   ☐ HPV (vaginal warts) ☐ Cervical dysplasia ☐ Breast fibroids
   ☐ Ovarian cysts ☐ Pelvic infections ☐ Infertility
   ☐ Increased facial and/or body hair growth

PATIENT SYMPTOM SEVERITY CHART

Please read the following list of symptoms and rank their severity from 0 to 6 on the corresponding lines.



SYMPTOMS	Today's Date / /	Follow-up 1 Date / /	Follow-up 2 Date / /	Follow-up 3 Date / /
Symptoms of Low Estrogen				
Dry Skin	________	________	________	________
Heart palpitations	________	________	________	________
Hot flashes	________	________	________	________
Inability to reach climax	________	________	________	________
Night sweats	________	________	________	________
Painful intercourse	________	________	________	________
Sleep disturbances	________	________	________	________
Urinary tract infections (UTIs)	________	________	________	________
Yeast infections	________	________	________	________
Symptoms of Low Progesterone				
Anxiety	________	________	________	________
Cramping	________	________	________	________
Symptoms of Low Testosterone				
Blunted motivation	________	________	________	________
Diminished feeling of well being	________	________	________	________
Fatigue, prolonged	________	________	________	________
General aches and pains	________	________	________	________
Muscle weakness	________	________	________	________
Symptoms of Both Low Estrogen and Testosterone				
Thinning skin	________	________	________	________
Vaginal dryness	________	________	________	________
Symptoms of Low Estrogen, Progesterone and/or Testosterone				
Depression	________	________	________	________
Fuzzy thinking	________	________	________	________
Hair loss	________	________	________	________
Headaches	________	________	________	________
Irritability	________	________	________	________
Low sex drive	________	________	________	________
Memory lapses	________	________	________	________

MENOPAUSE RATING SCALE (MRS)

Which of the following symptoms apply to you at this time? Please, mark the appropriate box for each symptom. For symptoms that do not apply, please mark 'none'.

Symptoms:	none	mild	moderate	severe	very severe
	|-----------|-----------|-----------|-----------|				
Score =	0	1	2	3	4
1. Hot flashes, sweating (episodes of sweating)……	☐	☐	☐	☐	☐
2. Heart discomfort (unusual awareness of heart beat, heart skipping, heart racing, tightness) ……	☐	☐	☐	☐	☐
3. Sleep problems (difficult in falling asleep, difficulty in sleeping through the night, waking up early) ……	☐	☐	☐	☐	☐
4. Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings) ……	☐	☐	☐	☐	☐
5. Irritability (feeling nervous, inner tension, feeling aggressive)……	☐	☐	☐	☐	☐
6. Anxiety (inner restlessness, feeling panicky) ……	☐	☐	☐	☐	☐
7. Physical and mental exhaustion (general decrease in performance, impaired memory, decrease in concentration, forgetfulness) ……	☐	☐	☐	☐	☐
8. Sexual problems (change in sexual desire, in sexual activity and satisfaction) ……	☐	☐	☐	☐	☐
9. Bladder problems (difficult in urinating, increased need to urinate, bladder incontinence) ……	☐	☐	☐	☐	☐
10. Dryness of vagina (sensation of dryness or burning in the vagina, difficulty with sexual intercourse) ……	☐	☐	☐	☐	☐
11. Joint and muscular discomfort (pain in the joints, rheumatoid complaints) ……	☐	☐	☐	☐	☐

Height _______ Weight ________ BMI (wt in kg/ht in meters sq) ________________________
(Pharmacist will calculate)

Waist Circumference__________ Hip Circumference___________ Waist/Hip Ratio_________________
(Pharmacist will calculate)

BMI (BODY MASS INDEX)

Severely underweight	BMI 16 or less
Underweight	BMI 16 to 19
Ideal	BMI 19 to 24
Moderately overweight	BMI 24 to 26
Overweight	BMI 26 to 30
Moderately obese	BMI 30 to 33
Obese	BMI 33 to 40

WAIST TO HIP RATIO

BMI and waist circumference are very important to the patient's general health. However, new evidence suggests waist to hip ration is more consistently a predictor of metabolic complications.

General waist to hip ratio guidelines:

AGE	LOW RISK*	MODERATE RISK*	HIGH RISK*	VERY HIGH RISK*
20-29	< 0.8	0.8-0.9	0.9-0.94	> 0.95
30-39	< 0.85	0.85-0.9	0.9-0.95	> 0.96
40-49	< 0.87	0.87-0.93	0.93-1.0	> 1.0
50-59	< 0.9	0.9-0.95	0.95-1.0	> 1.0
60-69	< 0.9	0.9-0.97	0.97-1.1	>1.1

*RISK OF DEVELOPING METABOLIC COMPLICATIONS

To:____________________________ Fax:__________________

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PATIENT NAME:______________

DOB:______________________

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PHARMACIST ASSESSMENT AND PLAN

PHARMACIST SIGNATURE:______________________________DATE:____________

PROVIDER SIGNATURE AND APPROVAL:______________________________

Comments:______________________________

Please fax this page back with signature to approve the pharmacist's recommendation

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Release Authorization

______I hereby release my Physician to furnish an agent of Pharmacy Compounding Solutions 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 Pharmacy Compounding Solutions will protect my privacy and this information will be released to other healthcare 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: ______________________________ Date of last visit ____________________
Physician Name:______________________________ Date of last visit ____________________
Physician Name:______________________________ Date of last visit ____________________

Patient Name:____
Address:____
City, State, Zip:____
Phone:____

Signature____ Date:__________________