

Compound Pharmaceutical Technologies, Inc. 1048 Stanton Road, Suite B Daphne, AL 36526 Phone Local: 251-626-2820 Phone Toll Free: 866-591-6337 Fax: 866-684-6337 www.cptinc.org

## CONFIDENTIAL FEMALE HORMONE FOLLOW-UP EVALUATION

	Today's Date:						
Name:				Birthdate:	Age:		
Address:							
		Street		City	State	Zip	
Phone:			Email:				
Height:	١	Veight:	Desired W	/eight:			
Allergies: Please	list any	allergies a	nd describe the	reaction that occurred			
Drugs: Foods: Other:							
Have you had an	y of the	following	tests since our la	ast consultation?			
Mammography	Yes	No	Date:	Outcome:			
PAP Smear	Yes	No	Date:	Outcome:			
Bone Density	Yes	No	Date:	Outcome:			
Have symptoms st No, please exp		your initia	al consult improv	ed?			
Yes							
What symptor	ns have	improved	? Mild Improven	nent Moderate Improve	ement Major Imp	provement	

Are there any new unpleasant symptoms since the initial consult?

## **Patient Name:**

Have you been compliant with the following under the recommended treatment plan?

Prescription Medications	Yes	No
Supplments	Yes	No
Dietary Changes	Yes	No

If you have answered no to the question above, are there any barriers prohibiting you from being compliant?

Have you had any changes to your medications or supplements since the initial consultation?

If you previously indicated having any of the following issues in the initial consultation, have they improved?

Stress	Yes	No	N/A	Please explain:
Sleep	Yes	No	N/A	Please explain:
Energy	Yes	No	N/A	Please explain:
Diet	Yes	No	N/A	Please explain:

Describe your diet:

How many meals per day? How many vegetables do you eat per day? How much fruit do you eat per day? How much protein do you eat per day? How much red meat do you eat per day? How much sugar or starches per day? How many wheat products per day? How many snacks per day?

What is the time frame between bowel movements? Examples: Once a day every other day or twice a day every day.

Please check any of the following gastrointestinal symptoms you are experiencing?

Cramps

Diarrhea

Constipation

Bloating

Gastric Reflux

## Patient Name:

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Aches & Pains	Thinning Skin				
Bone Loss	Aches & Pains				
	Bone Loss				

## **Patient Name:**

Have you met any of your goals while taking your Hormone Replacement Therapy?

- 1.
- 2.
- 3.
- 4.
- 5.
- .
- 6.

What questions have come up since the onset of your therapy?

Discuss the impact of the current therapy you have experienced from a quality-of-life perspective.

Discuss symptoms that have improved to current therapy.

Discuss areas not responding to current therapy.

Discuss any potential barriers preventing the patient from following current course of treatment.

Discuss any new developments or symptoms that need to be addressed.

\*\*\*THE FOLLOWING WILL BE FILLED OUT BY YOUR HEALTHCARE CONSULTANT\*\*\* Adjust, create new, or maintain current therapy on findings in the follow-up session if applicable.

Change in therapy recommendation sent to your physician to review if applicable.

\*\*\* Please include a copy of all relevant lab work since our last consultation, especially hormone levels that you have recently obtained.\*\*\*