

Carel's Pharmacy & Compounding Center
1810 W. Gore Blvd.
Lawton, OK 73501
(580) 355-4540
www.carelspharmacy.com

Please fill out the following form and return to the pharmacy so we may evaluate your progress of Bio-Identical Hormone Replacement. If any changes need to be made we will be in contact with you and your physician. If you have any questions or comments not covered on this form, please feel free to include them. Thank you!

Name _____ Date _____

Day Phone: _____ Night Phone: _____ Email: _____

How is the medication working for you? _____

What do you dislike about the medication? _____

What is your consistency in using this medication? _____

How are you using each individual medication? How many times daily? _____

Comments/Questions: _____

Please rate your current status for each symptom by checking the appropriate modifier.

	Absent	Mild	Moderate	Severe
Headaches	_____	_____	_____	_____
Low Libido	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____
Swollen or Tender Breasts	_____	_____	_____	_____
Fibrocystic Breasts	_____	_____	_____	_____
Fuzzy Thinking	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Food Cravings	_____	_____	_____	_____
Irritability	_____	_____	_____	_____
Insomnia	_____	_____	_____	_____

Cramps	_____	_____	_____	_____
Emotional/Mood Swings	_____	_____	_____	_____
Weight Gain	_____	_____	_____	_____
Bloating	_____	_____	_____	_____
Inability to Concentrate	_____	_____	_____	_____
Hot Flashes	_____	_____	_____	_____
Shortness of Breath	_____	_____	_____	_____
Night Sweats	_____	_____	_____	_____
Vaginal Dryness	_____	_____	_____	_____
Dry Hair/Skin	_____	_____	_____	_____
Hair Loss	_____	_____	_____	_____
Short Term Memory Loss	_____	_____	_____	_____
Frequent Urinary Tract/Yeast Infections	_____	_____	_____	_____
Heart Palpitations	_____	_____	_____	_____
Vaginal Shrinking	_____	_____	_____	_____
Loss of Pubic Hair	_____	_____	_____	_____
Painful Intercourse	_____	_____	_____	_____
Inability to Reach Orgasm	_____	_____	_____	_____
Fatigue Lack of Energy	_____	_____	_____	_____
Heavy or Irregular Menses	_____	_____	_____	_____
Uterine Fibroids	_____	_____	_____	_____

Age _____

Are you cycling? _____ If not, are you menopausal? _____

Have you had a hysterectomy? _____ If so, do your ovaries remain? _____

Are you interested in customized skin care? _____ If so, we will send you a skin care form.