Taylors Pharmacy 306 South Park Avenue, Winter Park, FL 32789 Telephone: 407- 644-1025 Fax 407-644-0160

Women's Health Education Form

Date:

Name: Date of Birth:

Address: City: State: Zip:

Telephone Contact # Occupation:

Physician: Primary Care: GYN:
Office Address: Telephone #:

Medication Allergies:
Soy☐ Lactose☐ Other:

Current Prescription Medications/Hormones:

Non–prescription medications/vitamins etc:

Are you using over the counter progesterone cream?:

Hormones used in the past:

Diseases Diagnosed by your physician:

Date of last Pap smear: Mammogram: Bone Density Test: Results of Tests:

Height: Weight: Age:

Why are you here today?
Referred by:

PHARMACY NOTES:

_____
_____
_____
_____

Please answer the following questions:	YES	NO	N/A/ At times	Comments
Have you ever given birth? If yes, how many times?	☐	☐	☐	
Have you ever had a miscarriage?	☐	☐		
Have you had a hysterectomy?	☐	☐		year?
If yes, was your cervix spared?	☐	☐		
Were your ovaries removed?	☐	☐		
Are you still menstruating?	☐	☐	☐	
Do you have uterine fibroids?	☐	☐	☐	
Do you have menstrual cramps?	☐	☐	☐	
Are you more irritable than usual?	☐	☐	☐	
Do you have severe mood swings?	☐	☐	☐	
Do you lose your temper easily?	☐	☐	☐	
Do you cry easily for no reason?	☐	☐	☐	
Do you suffer from headaches? Tension? Migraine? # of headaches/week?	☐	☐	☐	
Are they related to menstrual cycle?	☐	☐	☐	
Are you having difficulty remembering?	☐	☐	☐	
Do you have trouble concentrating?	☐	☐	☐	
Do you have problems sleeping?	☐	☐	☐	
Are you more fatigued?	☐	☐	☐	
Have you gained weight?	☐	☐	☐	
Do you have hair loss?	☐	☐	☐	
Do you have dry skin?	☐	☐	☐	
Do you have vaginal dryness?	☐	☐	☐	
Is intercourse painful?	☐	☐	☐	
Is your sex drive diminished?	☐	☐	☐	
If yes, is it of concern to you?	☐	☐	☐	
Do you feel depressed?	☐	☐	☐	
Do you feel anxious or nervous?	☐	☐	☐	
Do you have fluid retention?	☐	☐	☐	

	YES	NO	N/A At times	Comments
Do you have persistent breast tenderness?	☐	☐	☐	
Have you ever had breast cysts?	☐	☐	☐	
Have you had breast surgery for cysts:	☐	☐	☐	
Do you have night sweats?	☐	☐	☐	
Do you have hot flashes? If yes, # per day:	☐	☐	☐	
Do you get bladder infections?	☐	☐	☐	
Do you leak urine?	☐	☐	☐	
Do you crave carbohydrate foods?	☐	☐	☐	
Do you drink cola beverages?	☐	☐	☐	
Do you drink alcohol? Daily? Ocassionally?	☐	☐	☐	
Do you smoke?	☐	☐	☐	
Do you have high blood pressure?	☐	☐	☐	
Do you have high cholesterol?	☐	☐	☐	
Have you ever had a blood clot?	☐	☐	☐	
Do you have joint aches?	☐	☐	☐	
Do you exercise? #/times per week	☐	☐	☐	
Is there heart disease in the family? If yes, who?	☐	☐	☐	
Is there a history of cancer in the family? If yes, who?	☐	☐	☐	

Additional history and comments: