APOTHECARY OPTIONS
3006 Esplanade, Suite I, Chico, CA 95973
phone: 530-345-**RxRx** (7979) fax: 530-345-9797

Confidential Medical History
Women

Name: _____ **Birth Date:** _____ **Age:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Day Phone: (____) _____ **Night Phone:** (____) _____ **Cell Phone:** (____) _____

Email: _____

Height: _____ Weight: _____ General Health: _____ (excellent, good, fair, poor) Bone size: _____ (small, medium, large)

Body Type: Estrogenic ____ (shorter, full-breasted) Androgenic _____ (taller, small breasted) Somewhere in the Middle _____

Work Stress: Yes ____ No ____ Family Stress: Yes ____ No ____ Health Stress: Yes ____ No ____

	Yes	No	If **YES**, how often & how much?
Do you use tobacco?			
Do you use alcohol?			
Do you use caffeine?			
Do you exercise regularly?			

Allergies (medications, food, pollens?) _____

_____

_____

List all medications you are currently taking (include prescription, OTC, herbal remedies, and nutritional supplements): _____

_____

_____

Medical Conditions/Diseases. Please check all that apply to you.

- ☐ Heart disease
- ☐ High cholesterol or lipids
- ☐ High blood pressure
- ☐ Liver Disease
- ☐ Digestion problems (ulcers, colitis, irritable bowel)
- ☐ Thyroid disease
- ☐ Hormonal related issues (PMS, hot flashes)
- ☐ Endometriosis
- ☐ Osteoporosis
- ☐ Blood clotting problems
- ☐ Fibromyalgia
- ☐ Lung condition
- ☐ Diabetes
- ☐ Arthritis or joint problems
- ☐ Depression
- ☐ Epilepsy
- ☐ Headaches/migraines
- ☐ Eye disease (glaucoma, etc)
- ☐ Cancer: (specify) _____
- ☐ Autoimmune Diseases (specify) _____
- ☐ Varicose Veins
- ☐ Other: Please list _____

List Hormones Previously Taken	Date Started	Date Stopped & Reason for Stopping

Do you have a family history of any of the following?

Uterine Cancer _____ Family member(s) _____
Ovarian Cancer _____ Family member(s) _____
Fibrocystic breast _____ Family member(s) _____
Breast Cancer _____ Family member(s) _____
Heart Disease _____ Family member(s) _____
Osteoporosis _____ Family member(s) _____
Menstrual Problems _____ Family member(s) _____

Have you had any of the following tests performed? Check those that apply and indicate the approximate date (month/year) of last test.

Mammography ____ No ____ Yes _____ Date
Pap Smear ____ No ____ Yes _____ Date
Saliva Hormone Test ____ No ____ Yes _____ Date
Blood Hormone Test ____ No ____ Yes _____ Date
Bone Density Test ____ No ____ Yes _____ Date

Were any of your test results abnormal? Please explain: _____
_____

Age of first period _____ Number of months since last period _____
How many days from the start of one period to the start of the next? _____ **(currently)** _____ (**20's-30's**)
Since you first began having periods, have you ever had what you consider to be abnormal cycles?
____ No ____ Yes Please explain: _____
_____
Any bleeding between periods? When? _____
Any pelvic pain? _____ Describe: _____
Any unusual vaginal discharge or itching? _____ Describe: _____
_____

Do you have, or did you ever have Premenstrual Syndrome (PMS)? ____ No ____ Yes
If **YES**, please describe the severity of your PMS symptoms: _____
_____

Have you had a hysterectomy? ____ No ____ Yes Date of Surgery (approx.) _____
Have your ovaries been removed? ____ No ____ Yes
What was the reason for your surgery?_____
_____

Total pregnancies? _____ Age at first pregnancy? _____ Pregnancy problems? (describe) _____
_____

Age of relatives when they started menopause? Mother _____ Sister _____ Aunt _____

Your Name:	**Date:**

Make a copy of this information for yourself and then mail your completed Medical History along with your completed Patient Symptom Survey to: Apothecary Options, 3006 Esplanade, Suite I, Chico, CA 95973. You can also fax your information to 530-345-9797. Our pharmacists will review your completed form and then call you or e-mail you with a response. Note: Unless other arrangements have been made, our pharmacists will consult with you by phone after normal business hours.