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Pharmacist Progress Notes

Patient Name:_____ Initial Evaluation Date:_____
Address:_____ Phone #_____
Primary MD: _____MD Phone #_____
Primary Diagnosis: _____
Chief Complaint/Problem TODAY: _____
Todays's Date: _____

Data (Subjective/Objective):
_____
_____
_____
_____
_____
_____
_____

Assessment:
_____
_____
_____
_____
_____
_____

Plan:
_____
_____
_____
_____
_____
_____

Medical History Form

Please return this form to the Pharmacy when you have finished.
The Pharmacist will meet with you to review your information. Thank you.

1. **Patient Information**: Today's Date_____
Name:_____ Birthdate:_____

Address:_____ City:_____Zip:_____

Phone#: _____ Insurance Co._____

Gender: Male Female Height:_____ Weight: _____

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2. **Lifestyle Information:**

	Do you use? YES or NO	If YES, how often and how much
Tobacco (smoke, chew, dip)	_____	_____
Alcohol (beer, wine, hard liquor)	_____	_____
Caffeine (cola, drinks, tea, coffee)	_____	_____

Impairments: Check if you have any of the following:
___Physical Impairment ___Visual Impairment __Hearing impairment

Exercise: Do you exercise regularly? ___YES ___NO
If Yes, describe what you do and how ofter:

Stress Management: Do you practice any stress management techniques? __YES __NO

Pregnancy: Are you pregnant? ___YES ___NO

Diet: Describe your typical daily food intake:

First Meal: Second Meal: Third Meal: Any snack

3. Doctor Information: Are you currently under the care of a physician ___YES ___NO
If YES, please list each doctor from who you seek care, including address and phone

Doctor Name:_____Address_____Phone_____
Doctor Name:_____Address_____Phone_____
Doctor Name:_____Address_____Phone_____

4. Snap Caps: I request my prescription be dispensed in NON-CHILD PROOF container

_____

(signature) (Date)

ONLY SIGN HERE IF YOU WANT SNAP-CAP CLOSURES ON YOUR PRESCRIPTON CONTAINER

5.Allergies: Please check all that apply:

- ☐ penicillin ☐ morphine ☐dye allergies ☐ pet allergies
- ☐ codiene ☐ aspirin ☐ nitrate allergy ☐ seasonal allergies
- ☐ sulfa drug ☐ food allergies ☐ no known allergies other:_____

Please describe the allergic reaction you experienced and when it occurred:

6. Over-the counter (OTC) issues:

Indicate which of the following conditions you occasionally or regularly treat with Non-prescription (OTC) medications, herbal, vitamin/mineral, or homeopathic Remedies:

- ☐ Allergy symptoms ☐ Pain ☐ Arhtritis
- ☐ Cough and cold ☐ Fibromyalgia ☐ Heartburn
- ☐ Constipation ☐ Vaginal problems ☐ stomach problems
- ☐ Diarrhea ☐ Breathing or nasal problems ☐ Eye problems
- ☐ Weight control/dieting ☐ Other

Please check all products you use occasionally or regularly:

☐ Pain reliever. Check all that apply

- ☐ aspirin
- ☐ acetaminophen (Tylenol®)
- ☐ Ibuprofen (example: Motrin®)
- ☐ naproxen (example: Aleve®)
- ☐ Ketoprofen (example Orudis®)

☐ Combination product (cough & cold)

- ☐ Sleep aids (example: Excedrin PM®)
- ☐ Antidiarrheals (example: Imodium®)
- ☐ Laxative/stool softeners (Colace®)
- ☐ Diet Aids/weight loss products
- ☐ Antacids (example Maalox®)

☐ Cough Suppressants (example Robitussin®) ☐Acid blockers (example: Tagamet®)

☐ Antihistamine product (example: Chlor-Trimeton®) ☐ Other (please list)

☐ Decongestant products (example: Sudafed®) _____

☐ Nutritional/Natural Supplements: Please identify and list the products you are using:

☐ vitamins (examples:multiple or single vitamins such as B complex, E,C etc.)

_____

☐ minerals (examples: calcium, magnesium, chromium, colloidal minerals)

_____

 herbs (example: Ginseng, Ginkgo Biloba, Echinacea, medicinal teas etc.)

_____

 enzymes: (examples: digestive formulas, papaya, bromelain, CoEnzyme Q12)

_____

 Nutrition/ protein supplements (examples: shark cartilage, protein pwds)

_____

 Other (glucosamine, etc.)

7. Medical Conditions/Disease: Please checks all that apply to you:
__Heart Disease (example: Congestive Heart Failure)
__High cholesterol or lipids: (example: Hyperlipidemia)
__High Blood Pressure (example: Hypertension)
__Cancer
__Ulcers (stomach, esophagus)
__Thyroid Disease
__Eye disease (example Retinopathy, Glaucoma, Macular Degeneration)
__Lung Condition (example: astham, emphysema, COPD)
__Diabetes
__Arthritis or joint problems
__Depression
__Epliepsy
__Headaches/migraines
__Other: Please List:
_____

8. Prescription medications:
Please list all prescription medications you are curently using that were not obtained at this pharmacy. Be sure to include any mail order or physicians samples. We will manually check these against any prescription medications you obtain here for possible interactions.

Medication Name Date how many times per day? Doctor:

1. _____
2. _____
3. _____
4._____
5._____
6._____

Thank you,

+.HORMONE REPLACEMENT THERAPY PATIENT INFORMATION SHEET

Name_____
How did you arrive at the decision to take natural hormones? Doctor/Self/Friend
Bone Size?_____Small/Medium/Large
Body Type? _____Andorgenic/Estrogenic
Age? _____
How many pregnancies? _____
How many children? _____
Have you had a hysterectomy? □ No
□ Yes / If so when and what type? _____
What are your current symptoms? _____
_____

Is there a family history of:
Uterine Cancer? Yes □ No €
Ovarian Cancer? Yes € No €
Breast Cancer? Yes € No €
Osterporosis? Yes € No €
Heart Disease? Yes € No €

Were you prematurely gray? Yes € No €
As a teenager, were your periods normal? Yes € No €
Did you have PMS? If yes explain below Yes € No €
_____
_____

Have you experienced any of the following symptoms recently?

Symptoms	Yes	No	Symptoms	Yes	No
Sleep Disruption			Loss of Recent Memory		
Fatigue			Weight Gain		
Vaginal Dryness			Decrease Sex Drive		
Irritability			Depression		
Nervousness			Fluid Retention		
Breast Tenderness			Headaches		
Hot Flashes			Night Sweats		
Dry Skin			Hair Loss		
Mood Swings			Harder to Reach Climax		
Arthritis			Bladder Symptoms		

Thank you for completing this information. We will use it to better care for you.

Hormone Replacement Therapy Patient Information Sheet

Name_____

Have you experienced any of the following symptoms recently? Please circle the number that best describes your experiences, with one being Extremely Mild and ten being Extremely Severe.

Sleep Disruptions	1	2	3	4	5	6	7	8	9	10
Fatigue	1	2	3	4	5	6	7	8	9	10
Vaginal Dryness	1	2	3	4	5	6	7	8	9	10
Irritability	1	2	3	4	5	6	7	8	9	10
Nervousness	1	2	3	4	5	6	7	8	9	10
Breast Tenderness	1	2	3	4	5	6	7	8	9	10
Hot Flashes	1	2	3	4	5	6	7	8	9	10
Dry Skin	1	2	3	4	5	6	7	8	9	10
Mood Swings	1	2	3	4	5	6	7	8	9	10
Arthritis	1	2	3	4	5	6	7	8	9	10
Loss of Recent Memory	1	2	3	4	5	6	7	8	9	10
Weight Gain	1	2	3	4	5	6	7	8	9	10
Decreased Sex Drive	1	2	3	4	5	6	7	8	9	10
Depression	1	2	3	4	5	6	7	8	9	10
Fluid Retention	1	2	3	4	5	6	7	8	9	10
Headaches	1	2	3	4	5	6	7	8	9	10
Night Sweats	1	2	3	4	5	6	7	8	9	10
Hair Loss	1	2	3	4	5	6	7	8	9	10
Harder to Reach Climax	1	2	3	4	5	6	7	8	9	10

Name_____

Bladder Symptoms	1	2	3	4	5	6	7	8	9	10
Cold Hands Cold Feet	1	2	3	4	5	6	7	8	9	10
Other:	1	2	3	4	5	6	7	8	9	10

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