



The Compounding Apothecary
 (425)672-9888 or Toll Free: 1-877-522-4466 / FAX: (425)672-8809

300 Admiral Way Ste. 107
 Edmonds, WA 98020

Consultation Form
 Natural Hormone Replacement Therapy

Name: _____ Date: ___/___/___ Time In: _____ Time Out: _____ Fee: \$ _____
 Doctor: _____ Referred by: _____
 Birthdate: ___/___/___ Age: _____ Height: _____ Weight: _____ BP: ___/___ Blood Type: _____

1. Purpose of this Visit: List and describe the reason(s) you are here today -- in order of significance --also indicate how long you've had said condition(s).

- A. _____
- B. _____
- C. _____
- D. _____

Previous treatments attempted and results:

Your perception of the causes of the problems & treatments needed:

2. Medical History

A. Allergies -- please list any allergies you have:

- 1. Drugs: _____
- 2. Food: _____
- 3. Environment: _____

B. Do you have any problems with digestion?: _____

C. Do you drink alcohol? Light? Moderate? Heavy? _____

D. Do you smoke?: Light? Moderate? Heavy? _____

E. Do you crave certain foods? _____

F. Have you had any operations? _____

3. Prescription Medications

Name	Strength	Directions	Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. Over the Counter Medicines (including herbs, vitamins, homeopathy, etc.):

5. Activity Level Detail:
