Rx³ Compounding Pharmacy
Quality Reliability Integrity Excellence

Phone: 804-717-5000 • Toll Free: 888-384-5470

Chester • Fax: 804-717-8300
12230 Ironbridge Rd., Ste C • Chester VA 23831

Short Pump • Fax: 804-269-4304
11934 West Broad St. • Henrico VA 23233

Female Evaluation Brief

Please fax all completed forms prior to appointment to 804-269-4304 or email to Talonna@rx3pharmacy.com

Name: _____
Today's Date: _____
Nickname / Preferred Name: _____
Date of Birth: _____ Age: _____
Gender: _____ Frame: S M L
Current weight: _____ Ideal Weight: _____
Height: _____ Waist Measurement: _____
Hip Measurement: ____ Breast Measurement: ____
Prescription Insurance Carrier: _____
Group #: _____
Cardholder Name: _____
Relationship to Cardholder: _____
Employer: _____

Phone # that I may contact you at: _____
Email that I may contact you at: _____
Home Address: _____
_____
Referred by: _____
Primary Care Provider: _____
OBGYN: _____
Food Allergies: _____
Drug Allergies: _____
List ALL current medications/hormones & supplements: _____
_____
_____
_____

What are your health concerns? _____
What are your health priorities? _____
Prescription Preference: Pill ____ or Cream ____ vaginal cream ____ or vaginal suppository ____

Prior Surgeries/Date:

_____ Tubal Ligation: _____
_____ Hysterectomy: _____
_____ Ovarian cyst removal: _____
_____ Myomectomy: _____
_____ Female Reconstructive Surgery: _____

Current Diagnosis/Conditions:

_____ Endometriosis
_____ Uterine fibroids
_____ PMS
_____ Fibrocystic Breast Disease
_____ Cancer
Other: _____

HISTORY

Age at first period _____ Last Menstrual Period: _____
Average # of days in a normal cycle _____
Average # of days menstruating _____
Fibroids _____ yes _____ no
Blood Pressure _____ high _____ low
High Cholesterol _____ yes _____ no
Bone Mineral Density: _____ OK _____ Low _____ Never Tested

PREGNANCY

of pregnancies_____ # of births_____
Age at first pregnancy_____
____ Cardiac Complications
____ Palpitations
____ Shortness of breath
____ none
___ other _____

FAMILY HISTORY

	Cancer	Heart Disease	Osteoporosis	Diabetes
Mother				
Father				
Sibling				
Grandmother				
Grandfather				
Aunt				
Other				

HABITS

Do you use caffeine products? ____ yes ____ no
How much_____
Do you use tobacco products?____ yes ____ no
How much_____
Do you use alcohol products?____ yes ____ no
How much_____
Do you exercise routinely?____ yes ____ no
How much_____

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Please indicate which symptoms you are currently experiencing (write YES or NO. If YES, explain.)

Anxiety: _____
Bloating: _____
Body tender/sensitive to touch: _____
Cramping: _____
Craving salty food: _____
Dark circles under eyes: _____
Depression: _____
Difficulty Falling Asleep: _____
Difficulty Losing Gain: _____
Difficulty Staying Asleep: _____
Does your mind race at bedtime: _____
Dry Hair/Skin: _____
Emotional swings: _____
Energy crashes mid-afternoon: _____
Exhausted easily: _____
Fatigue, lack of energy: _____
Feel Overwhelmed: _____
Feel puffy/swollen all over: _____
Frequently ill: _____
Food cravings: _____
Frequent UTI's: _____
Frequent Yeast Infections: _____
Fuzzy thinking: _____

Hair Loss: _____
Headaches: _____
Heart Palpitations: _____
Hot Flashes: _____
Inability to Concentrate: _____
Inability to Reach Orgasm: _____
Irritability: _____
Loss of Pubic Hair: _____
Loss of Sex Drive: _____
Mood swings: _____
Nervousness: _____
Night Sweats: _____
Painful/Swollen Breasts: _____
Painful Intercourse: _____
Sensitive to changes in weather: _____
Shortness of Breath: _____
Short Term Memory Loss: _____
Vaginal Dryness: _____
Vaginal Shrinking: _____
Wounds heal slowly: _____

___ Have unusual fatigue unrelated to exertions?
___ Dress in layers because of needing to adjust to various temperatures?
___ Have trouble with weight, often eating lightly, yet still not losing a pound?
___ Experience aches/pains in muscles/joints unrelated to trauma or exercise?
___ Know of anyone in your family who has ever had a thyroid problem?
___ Family history of diabetes, anemia, rheumatoid arthritis, early graying hair?
___ Experience your hair as feeling like straw, dry and easily falling out?
___ Have significant menopausal symptoms or migraine despite estrogen?
___ Have a history of significant exposure to chlorine, bromine, or fluoride?
___ Feel chillier than others, often needing to wear socks to bed?
___ Have feelings of anxiety that sometimes lead to panic?
___ Suffer from dry skin, or are prone to adult acne or eczema?
___ Have increased problems with digestion or allergies?
___ Feel mentally sluggish, unfocused, or unusually forgetful?
___ Go through periods of depression, and/or lowered sex drive?
___ Have a history of whiplash or other neck injuries?
___ Feel utterly exhausted by evening, yet have trouble sleeping?
___ Do you wake up tired?

Date: _____ Signature: _____