Rx[3] 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

Follow up Female Evaluation for Consultation

From a clinical management point of view it is very useful to gain a detailed history of possible hormone deficiencies. The answers provided in the questions below will allow us to maintain your medical history and will help in advising about current medical therapies. All information will be kept confidential.

General Patient Information

Date ____/____/____
Name ______________________ Date of Birth ______________________ Age ________
Address(if new)______________________ City/State/Zip ______________________
Home Phone ______________________ Cell phone ______________________ Work Phone ______________________
Email ______________________ (only used by Rx3 and not sold to other entities)

Primary Care MD ______________________ Your Ob/Gyn ______________________
Address: ______________________ Address: ______________________
Tel #: ______________________ Tel # : ______________________

IS THERE A CHANGE IN YOUR INSURANCE?

Insurance Company ______________________ ID# ______________________
Policy Holder ______________________ Group # ______________________
Do you have Prescription Insurance? (example – Express Scripts, Caremark, Medco....)
We will need to obtain a copy of your insurance card.

At this point in the program, my primary goals and/or chief concerns are:
1. ______________________
2. ______________________
3. ______________________

I complied with the protocol/plan designed for me at the last visit and take my supplements and prescriptions as scheduled: (Check the answer that best describes you)

☐ Everyday ☐ 75% of the time ☐ 50% of the time ☐ 25% of the time ☐ Rarely

What challenges or obstacles keep you from following your plan and taking your supplements and prescriptions as scheduled?

I feel that the protocol/plan I've been following has helped me improve:

☐ by 100% ☐ by 75% ☐ by 50% ☐ 25% or less ☐ no improvement

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New Symptoms

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Habits

My appetite is: (circle the most appropriate answer) poor fair good very good out of control

My daily diet usually includes:

breakfast	
snack	
lunch	
snack	
dinner	
snack	

Dietary Restrictions ______________________________

Do you need help with your diet? ☐ No ☐ Yes

Do you get routine physical exercise? ☐ No ☐ Yes Type/Frequency/Duration ______________________________

Do you get at least 20 minutes of relaxation each day? ☐ No ☐ Yes

Do you get a restful night sleep? ☐ No ☐ Yes

Do you use tobacco products? ☐ No ☐ Yes How much ________ Previously ________ How long ________

Do you use alcohol products? ☐ No ☐ Yes How much ________ Previously ________ How long ________

Do you use caffeine products? ☐ No ☐ Yes How much ________

How much water do you drink daily? ____________

What stressors in your life contribute to your current state of health? ______________________________

____

Current Medical Status

Describe your current health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Height __________ Current Weight __________ Ideal Weight __________ Last Period __________

Current Medications: ______________________________ ______________________________

______________________________ ______________________________

Current Vitamins/Herbs/OTC: ______________________________ ______________________________

______________________________ ______________________________

Recent Mammogram? __________ Date______ Results ______________________________

Recent Cholesterol screen? __________ Date ______ Results ______________________________

Recent Bone Density scan? __________ Date ______ Results ______________________________

Recent Colonoscopy? __________ Date ______ Results ______________________________

Recent Blood Pressure? __________ Date______ Results ______________________________

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Symptoms I

Rate each symptom by checking the appropriate modifier. This section is repeated upon subsequent visits to monitor progress.

	Absent	Mild	Moderate	Severe
Headaches				
Frequently ill				
Anxiety				
Mood swings				
Fuzzy thinking				
Depression				
Irritability				
Bloating				
Cramping				
Food cravings				
Emotional swings				
Painful/Swollen Breasts				
Difficulty Losing Gain				
Difficulty Falling Asleep				
Difficulty Staying Asleep				

Symptoms II

Rate each symptom by checking the appropriate modifier. This section is repeated upon subsequent visits to monitor progress.

	Absent	Mild	Moderate	Severe
Hot Flashes				
Shortness of Breath				
Night Sweats				
Inability to Concentrate				
Vaginal Dryness				
Dry Hair/Skin				
Hair Loss				
Anxiety				
Nervousness				
Feel Overwhelmed				
Heart Palpitations				
Fuzzy Thinking				
Short Term Memory Loss				
Frequent UTI's				
Frequent Yeast Infections				
Vaginal Shrinking				
Loss of Pubic Hair				
Painful Intercourse				
Inability to Reach Orgasm				

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Symptoms III

Rate each symptom by checking the appropriate modifier. This section is repeated upon subsequent visits to monitor progress.

	Absent	Mild	Moderate	Severe
Energy crashes mid-afternoon				
Fatigue, lack of energy				
Craving salty food				
Exhausted easily				
Sensitive to changes in weather				
Loss of Sex Drive				
Dark circles under eyes				
Wounds heal slowly				
Body tender/sensitive to touch				
Feel puffy/swollen all over				
Does your mind race at bedtime				

Symptoms IV

Check the box if the statement applies to you.

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

If you would like us to share this information with your physician, please initial _______________

Please list the physician name and phone # ____

Date ____________________________ Signature ____

Your signature acknowledges your understanding of Rx3's Notice of Privacy Practices according to HIPAA regulations. It does not acknowledge your agreement or any restrictions you may have requested regarding your Protected Health Information.