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

# Wellness Consultation Evaluation

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

Name: _____ Phone # that I may contact you at: _____

Today's Date: _____ Email that I may contact you at: _____

Nickname / Preferred Name: _____ Home Address: _____

Date of Birth: _____ _____

Age: _____ Gender: _____ Name of general doctor: _____

Ethnicity: _____ Phone: _____

Are you pregnant/planning/lactating? _____ Name of other provider/specialist: _____

Phone: _____

| **Primary Health Concerns:** Please prioritize 1 or 2 health concerns that you would like to address during your first appointment. | *If applicable, list prior approaches related to your concerns:* | | |
|---|---|---|---|
| | **Prior Diagnoses** | **Prior Labs/Imaging** | **Prior Treatments** |
| **1)** | | | |
| **2)** | | | |

**NOTE:** If there is an extensive history associated with your health concern(s), please attach a separate piece of paper with a timeline of events, including symptoms, diagnoses, lab tests, treatments - what has helped & what hasn't, etc.

Please list other health concerns or symptoms that you are experiencing: _____

What expectations/goals do you have for your first consultation? _____

What are your long-term health goals while working with us? _____

What behaviors or lifestyle habits do you engage in regularly that you believe support your health? (please list) _____

What behaviors or lifestyle habits do you engage in regularly that you believe are destructive to your health? (please list) _____

To what extent are you open to addressing & changing lifestyle habits that may be contributing to your symptoms? Please circle:

(least open) 1 2 3 4 5 (most open)

What potential obstacles do you foresee in addressing the lifestyle factors and following recommended therapeutic protocols?

When did you last feel completely well? _____ Any significant events in the 6 months prior to becoming unwell?

(mention anything, even if it seems unrelated) _____

Any ideas about what triggered or caused your symptoms? _____

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## Medications & Supplements

**Current Prescriptions, Over-the-Counter Medications, & Supplements** (include oral, topical, and suppositories)
Please don't forget commonly used items such as antacids, aspirin, pain-relievers, & multivitamins

| **Name of Product** (Include brand for supplements) | **Date Started** | **Prescribed by** (Dr's name or Self) | **Reason for taking** | **Dosage** (ex. drugs: 100mg, 2 capsules, 1 tsp.) | **Frequency** (ex. 3x/day) | **Has it helped?** |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Do you have a history of extensive use of any of the following (please check):
• Antibiotics • Steroids (prednisone, cortisone, etc) • Hormone Therapy • If Yes, please explain:_____

Please circle the forms of supplements/medications that you prefer, and put an 'X' through any that you definitely do not like:
• No preference • Capsules • Tablets • Liquids • Powders • Tinctures (alcohol-based) • Teas • I have difficulty taking supplements
• Other:_____

## Past medical History

**Allergies & Sensitivities** Please list all substances that you react adversely to (even if the reaction is minor)

| | **Substance & Type of Reaction** (ex: peanuts --> Hives & breathing difficulty) |
|---|---|
| **Food** | |
| **Medicines & Supplements** | |
| **Environmental** (dust, trees, etc) | |
| **Other** | |

Have you ever experienced a life-threatening allergic reaction? Y / N If Yes, Please explain: _____

**Hospitalizations, Surgeries, & Major Illnesses** (remember to include infections such as Mono, Lyme Dz & surgeries such as removal of appendix, gallbladder, tonsils, as well as hysterectomies)

| **Age or Year** | **Condition or Procedure** | **Any ongoing problems related to this?** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Did you receive vaccinations as a child? Y / N As an adult? Y / N Any adverse reactions? Y / N / Maybe

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## Medical History Continued

Please list major childhood illnesses, with approximate age (include chronic/frequent infections such as strep throat & ear infections):

**Screening Exams** (Please check exams, labs, & imaging which you have received & indicate date of most recent:)

| | ✔ | Date | Normal Results | | | ✔ | Date | Normal Results | |
|---|---|---|---|---|---|---|---|---|---|
| **Physical Exam** | ☐ | | ☐ Yes | ☐ No | **Bone Density Scan** (DEXA) | ☐ | | ☐ Yes | ☐ No |
| **Cholesterol/Lipids** | ☐ | | ☐ Yes | ☐ No | **Mammogram** (females only) | ☐ | | ☐ Yes | ☐ No |
| **Blood Sugar** | ☐ | | ☐ Yes | ☐ No | **Pap Smear** (females only) | ☐ | | ☐ Yes | ☐ No |
| **Colon Cancer Screening** | | | | | **Prostate Check** (males only) | | | | |
| Colonoscopy | ☐ | | ☐ Yes | ☐ No | PSA | ☐ | | ☐ Yes | ☐ No |
| Sigmoidoscopy | ☐ | | ☐ Yes | ☐ No | Digital Rectal Exam | ☐ | | ☐ Yes | ☐ No |
| Fecal Occult Blood | ☐ | | ☐ Yes | ☐ No | | | | | |
| **EEG (Brain study)** | ☐ | | ☐ Yes | ☐ No | **CT Scan/ MRI for:**_____ | ☐ | | ☐ Yes | ☐ No |
| **EKG/ECG (Heart study)** | ☐ | | ☐ Yes | ☐ No | **X-ray for:**_____ | ☐ | | ☐ Yes | ☐ No |
| **HIV/STD Screen** | ☐ | | ☐ Yes | ☐ No | **Ultrasound for:**_____ | ☐ | | ☐ Yes | ☐ No |
| **Skin Cancer Screening** | ☐ | | ☐ Yes | ☐ No | **Other:**_____ | ☐ | | ☐ Yes | ☐ No |

## Family History

| | Father | Mother | Grandmother (maternal) | Grandmother (paternal) | Grandfather (maternal) | Grandfather (paternal) | Sibling 1 | Sibling 2 | Child | Self |
|---|---|---|---|---|---|---|---|---|---|---|
| Age (if living): | | | | | | | | | | |
| Health: G= Good; F= Fair; P=Poor | | | | | | | | | | |
| Age at death: | | | | | | | | | | |
| Cause of death: | | | | | | | | | | |
| ***Please check all that apply:*** | | | | | | | | | | |
| Alcohol/drug addiction | | | | | | | | | | |
| Allergies/eczema | | | | | | | | | | |
| Alzheimer's Dz or Dementia < age of 70 | | | | | | | | | | |
| Asthma | | | | | | | | | | |
| Autoimmune Dz | | | | | | | | | | |
| Cancer (list type) | | | | | | | | | | |
| Celiac Dz | | | | | | | | | | |
| Colitis / Crohn's | | | | | | | | | | |
| Depression | | | | | | | | | | |
| Diabetes | | | | | | | | | | |
| Epilepsy | | | | | | | | | | |
| Heart Disease | | | | | | | | | | |
| High Blood Pressure | | | | | | | | | | |
| High Cholesterol | | | | | | | | | | |
| Kidney Disease | | | | | | | | | | |
| Liver Disease | | | | | | | | | | |
| Mental Illness (specify) | | | | | | | | | | |
| Stroke | | | | | | | | | | |
| Other: | | | | | | | | | | |

Do any other significant medical conditions or symptoms run in, or are present in, your family? _____

# Review of Symptoms

***Please Circle As Follows:*** ***Y= a condition you have now,*** ***P= a condition you had in the past,*** ***N=no*** *(note: for past problems, only circle if they were significant. For example, everyone has had a cough due to a cold, so you don't need to circle this unless it was significant or recurrent).*

## General
Weight _____
Weight 1 yr. Ago _____
Maximum Weight _____
(when was this) _____
Desired Weight _____
Height _____
Fatigue Y P
Fever / Chills Y P
Night Sweats Y P
Unintentional weight
Gain or weight loss Y P
Sensitive to:
Smells/chemicals Y P
Light/noise Y P
Alcohol/medications Y P
Change in thirst? Y N
Change in appetite? Y N

## Skin, Hair, Nails
Rashes, hives Y P
Eczema Y P
Psoriasis Y P
Acne Y P
Itching Y P
Dry Skin Y P
Brittle Hair & Nails Y P

## Eyes
Impaired Vision Y P
Glasses/contacts Y P
Eye Pain Y P
Tearing or dryness Y P
Double vision Y P
Glaucoma Y P
Cataracts Y P
Poor Night Vision Y P
Dark circles under eyes Y P

## Ears
Impaired hearing Y P
Ringing in ears Y P
Earache Y P
Dizziness Y P

## Nose & Sinuses
Nose bleeds Y P
Stuffiness/Congestion Y P
Hayfever Y P
(seasonal allergies)
Post-Nasal Drip Y P

## Mouth and Throat
Frequent sore throat Y P
Thrush Y P
Gingivitis Y P
Hoarseness Y P
Dental cavities Y P
# of amalgam fillings: _____
Root Canals Y P

## Other:
_____
_____
_____
_____
_____

## Respiratory
Cough, dry Y P
Couch, productive Y P
Spitting up blood Y P
Wheezing Y P
Asthma Y P
Emphysema Y P
Bronchitis/Pneumonia Y P
Difficulty breathing Y P
Pain on breathing Y P
Shortness of breath
- with exertion Y P
- at night Y P
- lying down Y P
Tuberculosis Y P

## Cardiovascular
Heart Disease Y P
Stroke Y P
Angina (Chest Pain) Y P
Chest Tightness Y P
High Blood Pressure Y P
Low Blood Pressure Y P
High Cholesterol Y P
Murmurs Y P
Rheumatic fever Y P
Swelling in ankles Y P
Palpitations, fluttering Y P

## Peripheral Vascular
Deep leg pain Y P
Cold hands/feet Y P
Varicose veins Y P
Thrombophlebitis Y P
Deep Vein Thrombosis Y P

## Gastrointestinal
Trouble swallowing Y P
Heartburn Y P
Nausea Y P
Vomiting Y P
Vomiting blood Y P
Bloating Y P
Abdominal Pain Y P
Irritable Bowel Y P
Belching Y P
Flatulence (gas) Y P
Jaundice (yellow skin) Y P
Liver Disease Y P
Gall Bladder disease Y P
Ulcers Y P
Anal Pain or Itching Y P
Hemorrhoids Y P

## Bowel movements
How often? _____
Is this a change? _____
Blood in stool Y P
Mucous in stool Y P
Undigested food in stool Y P
Black stool Y P
Constipation Y P
Straining w/BM Y P
Diarrhea / Loose Stool Y P
Greasy/Fatty Stool Y P
Laxative Use Y P

## Urinary
Pain on urination Y P
Increased frequency Y P
Increased urgency Y P
Wake to urinate? Y P
If Y, _____ # x /night
Inability to hold urine Y P
Bladder infections Y P
Kidney Stones Y P
Kidney Infections Y P
Blood In Urine Y P
Pelvic Pain Y P

## Female Reproductive
Age menses began _____
# Days period lasts _____
# Days/cycle (e.g. 28) _____
Bleeding between periods Y P
Are cycles regular Y N
PMS Y P
Painful menses Y P
Excessive flow Y P
Diminished Flow Y P
Endometriosis Y P
Facial Hair Growth Y P
Ovarian Cysts Y P
Polycystic Ovaries Y P
# of pregnancies _____
# of live births _____
# of miscarriages _____
# of abortions _____
Difficulty conceiving Y P
Menopausal symptoms Y P
Age at Menopause _____
Sexually active? Y N
Birth Control Y N
What type? _____
Practice safe sex? Y N
Pain w/ intercourse Y P
Sexual difficulties Y P
STDs Y P
Sexual preference:
Heterosexual _____
Bisexual _____
Homosexual _____

## Breasts
Monthly Self Exams? Y N
Lumps Y P
Pain/tenderness Y P
Nipple Discharge Y P

## Male Reproductive
Hernias Y P
Testicular masses Y P
Testicular pain Y P
Prostate problems Y P
Sexually active? Y N
Practice safe sex? Y N
Sexual difficulties Y P
STDs Y P
Discharge or sores Y P
Sexual Preference:
Heterosexual _____
Bisexual _____
Homosexual _____

## Musculoskeletal
Joint pain or stiffness Y P
Arthritis:
Rhematoid Arthritis Y P
Osteoarthritis Y P
Muscle spasm/cramps Y P
Trauma / Accident Y P
Swelling Y P
Osteopenia/porosis Y P
Broken bones Y P
Sciatica Y P
Fibromyalgia Y P

## Neurologic
Fainting Y P
Seizures Y P
Paralysis Y P
Muscle weakness Y P
Numbness or tingling Y P
Loss of memory Y P
Vertigo Y P
Head Injury Y P
Headache Y P
Concussion Y P

## Mental / Emotional
Depression Y P
Mood Swings Y P
Anxiety or nervousness Y P
Panic Attacks Y P
Alcoholism Y P
Drug Dependency Y P
Eating disorder Y P
Mental Fog Y P
Attention deficit Y P
Take Vacations Y N
Watch TV (hours/day) _____
Read (hours/day) _____

## Endocrine
Hypothyroid / ↓ function Y P
Hyperthyroid / ↑ function Y P
Heat or cold intolerance Y P
Excessive thirst Y P
Excessive hunger Y P
Hormone Therapy Y P
Diabetes or pre-Diabetes Y P
Hypoglycemia Y P

## Blood / Immune
Anemia Y P
Easy bleeding or bruising Y P
Blood Transfusions Y P
Swollen glands/
lymph nodes Y P
Tick Bites Y P
Lyme Disease Y P
Mono / Epstein-Barr Y P
Cancer Y P
HIV / AIDS Y P
Autoimmune Disease Y P

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## Lifestyle

**Diet and Habits:** How often do you consume the following?
Key: 0=never, 1=rarely (1-4x/month), 2=often (2-4x/week), 3=regularly (5-7x/week)

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Water | ____ cups/day | | | Fast food (lighter choices) | 0 | 1 | 2 | 3 | Yogurt | 0 | 1 | 2 | 3 |
| Coffee | ____ cups/day | | | White flour (bread, pastry) | 0 | 1 | 2 | 3 | Cheese | 0 | 1 | 2 | 3 |
| Tea (type:_____) | ____ cups/day | | | White Rice | 0 | 1 | 2 | 3 | Eggs | 0 | 1 | 2 | 3 |
| Soda | 0 | 1 | 2 | 3 | Whole Grains & Brown Rice | 0 | 1 | 2 | 3 | Chocolate | 0 | 1 | 2 | 3 |
| Fruit Juice | 0 | 1 | 2 | 3 | Fish | 0 | 1 | 2 | 3 | Sweets (candy, cookies, cake) | 0 | 1 | 2 | 3 |
| Fruit | 0 | 1 | 2 | 3 | Poultry | 0 | 1 | 2 | 3 | Salty Snacks (chips, pretzels) | 0 | 1 | 2 | 3 |
| Vegetables | 0 | 1 | 2 | 3 | Red Meat | 0 | 1 | 2 | 3 | Artificial Sweeteners* | 0 | 1 | 2 | 3 |
| Legumes, beans | 0 | 1 | 2 | 3 | Unfermented soy (soy milk) | 0 | 1 | 2 | 3 | Alcohol | ____ drinks/wk | | | |
| Nuts/Seeds | 0 | 1 | 2 | 3 | Fermented soy (tofu, tempeh) | 0 | 1 | 2 | 3 | Cigarettes/tobacco | ____ packs/day<br>____ # of years | | | |
| Fast food (fried) | 0 | 1 | 2 | 3 | Milk, cream | 0 | 1 | 2 | 3 | Recreational Drugs | Type:_____<br>Frequency:___ | | | |

* Artificial sweeteners include aspartame (nutrasweet), saccharin, and sucralose; they're found in diet sodas & other sugar-free foods.
Are you a vegetarian or vegan? Y / N If Yes, what type and for how long? _____
Do you currently follow any 'named' diets (i.e. Atkin's, South Beach, etc)? Y / N If Yes, which one? _____
Do you avoid any foods or food groups (i.e. dairy, gluten-containing foods, etc)? Y / N If Yes, please list foods & reasons:
_____
List specific foods that you crave (Women -put a star next to foods craved premenstrually): _____
_____

**Please list typical meals/foods consumed throughout the day:**

| | |
|---|---|
| Breakfast: | Dinner: |
| Lunch: | Snacks: |

Do you feel that you have a healthy relationship with food? Y / N If No, Please Explain: _____
_____

**Sleep:** Please check all sleep issues that apply

Average hours of sleep per night: _____ hours/night Typical bedtime: _____ Typical 'wake time': _____

- ☐ trouble falling asleep initially
- ☐ very sleepy during day
- ☐ restless legs
- ☐ waking up gasping for air
- ☐ stimuli (including snoring partners)
- ☐ waking up too early in am
- ☐ frequent waking during the night to urinate
- ☐ grinding teeth
- ☐ partner complains that I snore
- ☐ racing thoughts preventing sleep
- ☐ waking unrefreshed & irritable
- ☐ pain or physical disorder prevents sleep
- ☐ reflux or heartburn
- ☐ sensitive to noise/light/environmental
- ☐ procrastinating going to sleep

**Exercise:** Please list typical activities in a usual week

| Type of exercise: | # of days per week | Duration per session | Indoors or Outdoors |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Energy Level:**
What time of day is your energy best? _____ Worst? _____
Rate your stress level: Circle: 0 1 3 4 5 (most stress)
Rate your energy level: Circle: 0 1 2 3 4 5 (most energy)

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## Social & Environmental History

### Work

Occupation:_____ Employer: _____ Hrs/Week of Work (Avg):_____

Please check any of the following stressors that apply to your occupation:

☐chemical/toxin exposure ☐heavy lifting ☐prolonged standing/walking ☐computer work
☐high stress ☐graveyard shift ☐long hours ☐difficulties with coworkers
☐other:_____

How do you feel about your job/career?_____

### Environment:

Have you had any toxic environmental exposures in your lifetime? Y N Maybe If Yes or Maybe, please explain:_____

_____

Do you buy any organic produce? ☐never ☐rarely ☐often ☐mostly ☐always

Do you buy hormone-free & antibiotic-free meat, poultry, and dairy? ☐never ☐rarely ☐often ☐mostly ☐always

Do you frequently encounter chemicals or toxins with any of your hobbies (i.e. insecticides w/ gardening, lead solder, etc)? Y / N

If yes, please explain:_____

### Support & Emotional Health:

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

_____

Are you content with your relationships and support system? _____

Are you: ☐married ☐separated ☐divorced ☐widowed ☐significant partner ☐single ☐other:_____

Live with:☐spouse ☐partner ☐relatives ☐friends ☐parents ☐kids ☐alone ☐pets:_____ ☐other:_____

Please list any children and their ages: _____

Do you feel safe in your living environments (home, work, school, etc)? ☐Yes ☐No

Is there anyone in your life whom you are afraid of? ☐Yes ☐No

What are some of your main hobbies & interests? _____

What brings you joy in life? _____

What are some of your current challenges in life? _____

What do you do to relieve stress?_____

Please list any predominant emotions that you have felt lately: _____

Please list 5 important events in your life from most recent to most distant:

1.) _____ Date/Age: _____/_____
2.) _____ Date/Age: _____/_____
3.) _____ Date/Age: _____/_____
4.) _____ Date/Age: _____/_____
5.) _____ Date/Age: _____/_____

Is there anything else that you want me to know about you? _____

_____

Thank you very much for taking the time to fill out this form! If possible, please return this form via fax, email, or regular mail 3 days prior to our appointment so that I may review it ahead of time. Otherwise, please bring your completed form with you to the pharmacy for your first appointment.