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Patient Consultation-General

GENERAL INFORMATION

Name: _____ DOB: _____
Address: _____
Home Phone: _____ Work Phone: _____ Cell: _____
Weight: _____ Height: _____
Sex: _____ Male _____ Female Email: _____
Referred By: _____

What are your goals for this consultation?

MEDICAL STATUS

Current diagnosis or medical conditions: _____

Current medications: _____

Current vitamins or OTC products: _____

Current herbs/etc.: _____

LIFESTYLE

Do you get routine physical exercise: _____ What type: _____
_____ How often: _____
Do you use tobacco products: _____ How much: _____ Previously: _____
How long: _____
Do you use alcohol products: _____ How much: _____
Previously: _____ How long: _____
Do you use caffeine products: _____ How much: _____
Describe your typical, daily diet: _____

FAMILY HISTORY

Please list family members who have or have had important diseases such as high cholesterol, high blood pressure, heart disease, stroke, diabetes, etc.:

- 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, yet 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, 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 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?

Rate your current status for each symptom by checking the appropriate modifier. Please feel free to use additional space to describe any symptom. This section may be repeated upon subsequent visits.

	Absent	Mild	Moderate	Severe
1. Energy crashes mid-afternoon	_____	_____	_____	_____
2. Fatigue, Lack of Energy	_____	_____	_____	_____
3. Craving for salty food	_____	_____	_____	_____
4. Exhausted Easily	_____	_____	_____	_____
5. Sensitive to changes in weather	_____	_____	_____	_____
6. Loss of Sex Drive	_____	_____	_____	_____
7. Dark circles under eyes	_____	_____	_____	_____
8. Wounds heal slowly	_____	_____	_____	_____
9. body tender/sensitive to touch	_____	_____	_____	_____
10. Feel puffy/swollen all over	_____	_____	_____	_____

Would you like us to share this information with your physician? _____ YES _____ NO
 If yes, please list the doctor's name(s): _____

Date: _____ Signature: _____

Since health information may change periodically, please notify your South River Compounding Pharmacy, Inc. pharmacist of any new medications (prescription and nonprescription), allergies, drug reactions or health conditions.
 Your signature acknowledges your receipt of [SRCP's Notice of Privacy Practices](#) according to New Federal Government HIPAA Regulations (This notice describes how medical information about you may be used and disclosed). It does not acknowledge your agreement or any restrictions you may request regarding your Protected Health Information.