South River Compounding Pharmacy, Inc.

2300 Robious Station Circle
Midlothian, VA 23113
Fax: 804-897-6449

3656 Mayland Ct
Richmond, VA 23233
Fax: 804-967-6449

(804) 897-6447 Toll Free: 1-888-879-7713
www.southriverRx.com Email: info@southriverRx.com

Brief Female Evaluation

Name:_____Today's date:_____
Address:_____
City:_____ State:_____ Zip:_____
Home phone:_____ Work phone:_____ E-mail:_____
Primary Care Provider:_____ OB/GYN:_____
Referred by: _____
Date of birth:_____Current Weight:_____ Ideal Weight:_____Height:_____ Waist Measurement:_____
Hip Measurement:_____Breast Measurement:_____ Frame: S M L
Prescription Insurance Carrier:_____ ID#_____
Group#_____ Cardholder name:_____
Relationship to cardholder:_____ Employer:_____
Drug Allergies:_____
Food Allergies:_____
List **All** Current Medications/Hormones and supplements:
_____
_____
_____
What are your health goals?_____
_____
Prescription preferences: 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:_____

Please indicate which symptoms you are currently experiencing

	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				

	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				
	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				

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_____

History:

Number of pregnancies_____
Age at first period_____
Average number of days menstruating_____
Average number of days in a normal cycle_____
Fibroids ___yes___no
Blood Pressure _____high_____low
High Cholesterol ___yes___no
Last Menstrual Period:_____
Bone Mineral Density:_____OK_____Low_____Never Tested

Age at first pregnancy_____
Number of births_____
_____ Cardiac Complications
_____ Palpitations
_____ Shortness of breath
_____ none
_____ other _____

Family History:

	History Heart Disease	History Cancer	History Osteoporosis	History Diabetes
mother				
father				
sibling				
grandmother				
grandfather				
aunt				
Other				

Please List a brief example of a typical day's diet

breakfast	
snack	
lunch	
snack	
dinner	
snack	

Daily Water Intake:_____

- ☐ 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?

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. 12/2011br