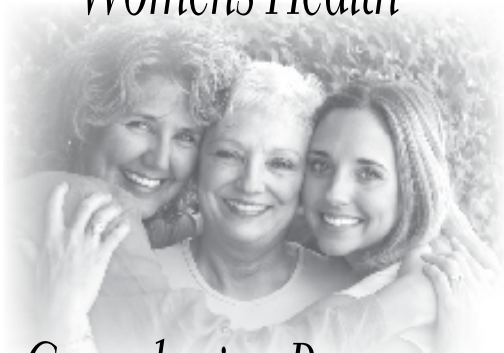


Women's Health



Consultation Program

Dell Pharmacy

You have been scheduled for a consultation with:

Date/Time: _____

To maximize the time you have with the consultant please send or drop off this questionnaire in advance or arrive 30 minutes before your appointment to allow our pharmacist to review your answers and prepare for the meeting.

Name: _____

Date of Initial Appointment: _____

Date of Follow-up Appointment: _____

Consultation includes:

- Discussion of lifestyle matters
- Review of your medical history, current medications, vitamins & supplements
- Assessment and review of symptoms
- Discussion of possible short and long term risk factors
- Discussion of conventional and alternative therapies and treatments

- 1. Initial Consultation... \$165.00**
60 minute One-on-One Consultation, Plus Written Report for the Patient.
(Pharmacist reviews this questionnaire for 30 minutes prior to meeting with Patient)
- 2. Communication with MD...\$30.00**
- 3. Follow-up with Patient... \$75.00**
- 4. OPTION:
Bundle All Above... \$245.00**

All costs subject to HST.

C O N F I D E N T I A L E V A L U A T I O N

To maximize your time with our Credentialed Pharmacist please fill out the following pages of this questionnaire as best you can and send or drop off to the pharmacy before your consultation.

Dell Pharmacy
www.dellpharmacy.com

C O N F I D E N T I A L E V A L U A T I O N

GENERAL INFORMATION

Name: _____ Birth Date: _____

Address: _____

Email: _____ Home Phone: _____ Work Phone: _____

LIVING SITUATION

Alone: __ Partner: __ Children: _____ Other: _____

What are your main concerns or questions that you would like to address during your appointment?

Were you referred, if so by whom? _____

LIFE STYLE INFORMATION

Diet (Your typical daily food intake would include)

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Water/Liquid Consumption: _____

What dairy products do you consume each day and how much?

Are you lactose intolerant (have a milk allergy)? YES __ NO __

TOBACCO USE

Do you currently smoke? YES __ NO __

If yes, how much per day? _____

OFFICE USE

C O N F I D E N T I A L E V A L U A T I O N

How do you feel about quitting smoking?

If you smoked in the past, when did you quit?

ALCOHOL USE

Do you drink alcohol? _____ If yes, how many drinks per week? _____

EXERCISE

If you exercise, what do you do?

For how long and how often?

STRESS MANAGEMENT

What are the current major stressors in you life?

How do you handle stress?

What do you do to relax?

MEDICAL STATUS

Do you consider your health to be:

Excellent _____ Good _____ Fair _____ Poor _____

Current height: _____ What was your maximum height? _____ At what age? _____

Current weight: _____

What was your maximum weight that you remember? _____ At what age? _____

What was your minimum weight that you remember? _____ At what age? _____

Waist circumference: _____

Is your body shaped like an apple _____ or a pear _____ or neither _____?

Allergies (Please describe the allergic reaction you experienced and when it occurred)

Medication _____

Food _____

Environmental _____

OFFICE USE

C O N F I D E N T I A L E V A L U A T I O N

Have you ever had a mammogram: _____ Date: _____

Results: _____

Have you ever had a bone density scan: _____ Date: _____

Results: _____

History of Fractures? _____

FAMILY HISTORY

Please list family history of any diseases such as: High Blood Pressure, Heart Disease, Cancer, Diabetes, Osteoporosis, etc.

GYNECOLOGICAL HISTORY

Age at your first period: _____ Date of last period: _____

Date of last pelvic exam: _____ Pap Smear: _____
Result: _____

Have you ever had an abnormal Pap: _____ Treatment: _____

Number of days of flow: _____ Presence of Premenstrual Syndrome (PMS): _____
Symptoms of PMS _____

Heavy, medium or light bleeding? _____
Any bleeding between periods: _____
How many days from start of one period to the start of the next: _____

Are you sexually active: _____ Are you trying to get pregnant: _____
Current birth control method: _____
Past birth control and any related problems: _____

Past use of any hormone therapy or similar treatments (what/how long/side effects/ etc):

Pelvic pain, pressure or fullness (Please describe): _____

Unusual vaginal discharge or itching (Please describe): _____

Treatment: _____

OFFICE USE

C O N F I D E N T I A L E V A L U A T I O N

Symptom Group 3

	Mild	Moderate	Severe
Puffiness and Bloating	_____	_____	_____
Rapid Weight Gain	_____	_____	_____
Tender Breasts	_____	_____	_____
Mood Swings	_____	_____	_____
Heavy Bleeding	_____	_____	_____
Anxious Depression	_____	_____	_____
Migraine Headache	_____	_____	_____
Insomnia	_____	_____	_____
Foggy Thinking	_____	_____	_____
Weepiness	_____	_____	_____

Symptom Group 4

	Mild	Moderate	Severe
Increased Acne	_____	_____	_____
Oily Skin	_____	_____	_____
Excessive Facial Hair	_____	_____	_____
Unstable Blood Sugar	_____	_____	_____
Loss of Scalp Hair	_____	_____	_____
Mid-cycle Pain	_____	_____	_____

Symptom Group 5

	Mild	Moderate	Severe
Low Libido	_____	_____	_____
Fatigue	_____	_____	_____
Decreased Muscle Mass	_____	_____	_____
Thinning of Skin	_____	_____	_____
Dry Hair/Skin	_____	_____	_____
Bone Loss	_____	_____	_____
Weak Muscles	_____	_____	_____
Painful Joints	_____	_____	_____

Additional Notes:

OFFICE USE

Date: _____ Signature: _____