KIZER Rx Pharmacy

Confidential **Wellness** Assessment

Name:_____

Today's Date:_____ Birthdate:_____ Age:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Mobile:_____

E-mail Address:_____

Gender: ❑ Male ❑ Female Height:_____ Weight:_____

Current Physicians/Healthcare Providers (Name, Address, Phone, Fax, Email if known)

_____

_____

_____

_____

Medical History

Medical Conditions/Disease States: (Please check all that apply to you)

- ❑ Heart disease (ex: Congestive Heart Disease)
- ❑ High Cholesterol or Lipids (ex: Hyperlipidemia)
- ❑ High Blood Pressure (Hypertension)
- ❑ Fibromyalgia or Chronic Fatigue
- ❑ Ulcers (stomach, esophagus)
- ❑ Thyroid Disease
- ❑ Hormone Related Issues
- ❑ Blood clotting problems
- ❑ Diabetes or Insulin Resistance
- ❑ Arthritis or Joint problems
- ❑ Depression
- ❑ Epilepsy
- ❑ Headaches/Migraines
- ❑ Eye Disease
- ❑ Lung Condition (ex: asthma, emphysema, COPD)
- ❑ Autoimmune Disease If checked, type:_____
- ❑ Chronic Pain If checked, type of pain:_____
- ❑ Cancer If checked, type of cancer:_____

Other (Please list)_____

Do you have a family history of any of the following?

- ❑ Uterine Cancer Family member(s)_____
- ❑ Ovarian Cancer Family member(s)_____
- ❑ Breast Cancer Family member(s)_____
- ❑ Fibrocystic Breast Family member(s)_____
- ❑ Heart Disease Family member(s)_____
- ❑ Osteoporosis Family member(s)_____
- ❑ Thyroid Disease Family member(s)_____
- ❑ Autoimmune Disease Family member(s)_____

Allergies: Please check all that apply. ❑ no known allergies

❑ penicillin ❑ morphine ❑ dye allergies ❑ pet allergies

❑ codeine ❑ aspirin ❑ nitrate allergy ❑ seasonal(pollen)

❑ sulfa drugs ❑ food allergies other_____

Please describe the allergic reaction you experienced and when it occurred.

_____

_____

_____

_____

Current Prescription Medications:

Medication Name	Strength	Directions	Date Started

Over the Counter (OTC) issues: Please check all products that you use occasionally or regularly. Check all that apply.

Pain reliever/anti-inflammatory:

- ❑ Aspirin
- ❑ Acetaminophen
- ❑ Ibuprofen
- ❑ Naproxen
- ❑ Other

Combination Cold Products:

- ❑ Cough suppressant
- ❑ Antihistamine product
- ❑ Decongestant Product
- ❑ Combination cold product

Other:

- ❑ Sleep Aid
- ❑ Antidiarrheal
- ❑ Laxatives/stool softeners
- ❑ Diet aids/weight loss products
- ❑ Antacid
- ❑ Acid blocker
- ❑ Other

_____

_____

_____

Supplements: Please identify and list the products you are using:

Vitamins (ex. Multivitamin or single vitamin such as B complex, E, C, D)

_____

Minerals (ex. Calcium, Magnesium, Chromium)

_____

Herbs (ex: Ginseng, Ginko Biloba, Echinacea, herbal medicinal teas)

_____

Enzymes (ex. Digestive formulas, papaya, bromelain)

_____

Nutritional/protein supplements (ex. protein powders, amino acids, fish oils)

_____

Others, please list: _____

_____

_____

List use of:			Qty	Daily	Weekly	Monthly	Occasionally
Tobacco?	❑ No	❑ Yes	____	❑	❑	❑	❑
Alcohol?	❑ No	❑ Yes	____	❑	❑	❑	❑
Caffeine?	❑ No	❑ Yes	____	❑	❑	❑	❑

Have you ever used oral contraceptives? ❑ No ❑ Yes

If yes, did you experience any problems? ❑ No ❑ Yes

If Yes, please describe any other health problem(s), concerns.

_____

_____

_____

_____

SYMPTOM SURVEY

Completing this form is particularly helpful if you have experienced persistent and bothersome symptoms from more than one category below. Score every symptom based on your experience over the last 30 days. Start with the first symptom and ask yourself, "Lately, have I experienced this symptom?" If you answer no or almost not at all, then write a "0" in the corresponding field. If the answer is yes, then ask yourself if you experience the symptom occasionally (less than 2 times in a week) or frequently (2 or more times in a week). After you have decided on the frequency, then ask yourself if the symptom is "Severe" or "Not Severe". Using the SCALE OF SYMPTOM POINTS

listed below, write the appropriate score in the corresponding field for EVERY symptom listed.

SCALE OF SYMPTOM POINTS: 0 = Do Not Suffer From This Ever or Almost Ever 1 = Suffer OCCASSIONALLY (less than 2 times per week), is not severe 2 = Suffer FREQUENTLY (2 or more times per week), is not severe 3 = Suffer OCCASSIONALLY and is severe 4 = Suffer FREQUENTLY and is severe	Grand Total:

CONSTITUTIONAL

_____ Fatigue (sluggish, tired)
_____ Hyperactive (nervous energy)
_____ Restless (can't relax/sit still)
_____ Sleepiness During Day
_____ Insomnia at Night
_____ Malaise
_____ TOTAL (0-20)

EMOTIONAL/MENTAL

_____ Depression (feelings of hopelessness)
_____ Anxiety (vague fears, uneasiness)
_____ Mood Swings (rapid distinct changes)
_____ Irritability
_____ Forgetfulness
_____ Lack of concentration/focus
_____ TOTAL (0-24)

HEAD/EARS

_____ Headache (any kind)
_____ Migraine (diagnosed)
_____ Earache
_____ Ear Infection
_____ Ringing in Ear
_____ Itchy Ears
_____TOTAL (0-24)

SKIN

_____ Blemishes, Acne
_____ Rashes, Hives
_____ Eczema
_____ "Rosy" Cheeks
_____ TOTAL (0-16)

NASAL/SINUS

____ Post Nasal Drip
____ Sinus Pain
____ Runny Nose
____ Stuffy Nose
____ Sneezing
____ TOTAL (0-20)

MOUTH/THROAT

_____ Sore Throat
_____ Swollen Throat
_____ Swelling of Lips/Tongue
_____ Gagging/Throat Clearing
_____ Lesions ("Canker Sores")
_____ TOTAL (0-20)

LUNGS

_____ Wheezing" (Asthma or Asthma-like Symptoms)
_____ Chest Congestion
_____ Non-Productive Coughing
_____ Productive Coughing
_____ TOTAL (0-20)

EYES

_____ Red or Swollen Eyes
_____ Watery Eyes
_____ Itchy Eyes
_____ Dark Circles" or "Baggy"
_____ TOTAL (0-16)

GENITOURINARY

_____ Increased Urinary Frequency
_____ Painful Urination
_____ TOTAL (0-8)

MUSCULOSKELETAL

_____ Joint Pains/Aching
_____ Stiff Joints
_____ Muscle Aches
_____ Stiff Muscles
_____ TOTAL (0-20)

CARDIOVASCULAR

_____ Irregular Heartbeat
_____ High Blood Pressure _____
TOTAL (0-8)

DIGESTIVE

_____ Heartburn/Esoph.Reflux
_____ Stomach Pains/Cramps
_____ Intestinal Pains/Cramps
_____ Constipation
_____ Diarrhea
_____ Bloating Sensation
_____ Gas (of Any Kind)
_____ Nausea, Vomiting
_____ Painful Elimination
_____ TOTAL (0-36)

WEIGHT MANAGEMENT

_____ **Record Actual Weight**
_____ **Approximate Height**
_____ Fluctuating Weight
_____ Food Cravings
_____ Water Retention
_____ Binge Eating or Drinking
_____ Purging (all methods)
_____ TOTAL (0-20)

Comments:

KIZER Rx Pharmacy
1117 South Miles Avenue, Suite 1, Union City, Tennessee 38261
Phone: 731.885.2226 Fax: 731.885.2291

Primary Goals/Concerns:

_____

_____

_____

_____

_____

Wellness Plan:

PHASE 1:

PHASE 2:

PHASE 3: