



Educating Women on Health & Life

Informed Females

Tara L. Fricke, Pharm.D.

Medication and Vitamin Supplement Questionnaire

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by your clinician during your consultation. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. These questions will help to identify underlying causes of illness and will help to formulate a treatment plan.

First Name: _____ Middle Name _____ Last Name _____

Address: _____ City: _____ State: _____ Zip Code _____

Home Phone:(_____) _____ - _____ Birth Date ____/____/____ Age: _____

Work Phone:(_____) _____ - _____ Cell Phone:(_____) _____ - _____

Email: _____

Place of Birth: _____

Occupation: _____ Height: _____ Weight: _____ Sex _____

Referred by: _____



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1. Please check appropriate:

African - American _____ Hispanic _____ Mediterranean _____ Asian _____

Native American _____ Caucasian _____ Northern European _____ Other _____

2. Please list current problems in order of priority

Describe Problem	Mild/Moderate/Severe	Current Treatment	Success
Example: hot flashes	Severe	OTC medication	Mild

3. With whom do you live? (Include spouse, children, parents, relatives, and/or friends. Please include ages.)

4. Do you have any pets? _____yes _____no

5. Have you or your family recently experienced any major life changes?
 _____yes _____no



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6. Allergies: Please check all those that apply.

penicillin morphine dye allergies pet allergies

codeine aspirin nitrate allergy seasonal allergies

sulfa drug food allergy no known allergies other

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

7. **Doctor's Name(s):**

Address:

Phone:

8. Medical Conditions/Diseases: Please check all that apply to you.

- | | |
|---|---|
| <input type="checkbox"/> Heart disease (example: Congestive Heart Failure) | <input type="checkbox"/> Blood Clotting Problems |
| <input type="checkbox"/> High cholesterol or lipids (example: hyperlipidemia) | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Arthritis / joint problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Ulcers(stomach, esophagus) | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Headache/ Migraines |
| <input type="checkbox"/> Hormonal related issues | <input type="checkbox"/> Eye disease (glaucoma) |
| <input type="checkbox"/> Lung disease(asthma, COPD, emphysema) | <input type="checkbox"/> Other: Please list |

9. Medication Names including Prescription and Over-the Counter

Vitamin/Mineral/Supplement name	Strength	How often per day

11. Do you exercise regularly? _____yes_____no_____sometimes

What kind? _____

How many days per week? _____

For Women Only

12. Have you ever been pregnant? (If no, skip to question 13.) _____yes_____no

Number of miscarriages:_____ Number of abortions:_____ Number of Preemies_____

Number of term births _____

Did you develop toxemia? (high blood pressure) _____yes_____no

Have you had other problems with pregnancy? _____yes_____no

If so, please

explain: _____

13. Age at first period:_____ Date of last Pap smear:_____ Normal__Abnormal_____

Date of last mammogram _____ Normal _____ Abnormal _____

14. Have you ever used birth control pills? _____yes_____no

If yes, when? _____

15. Are you in menopause? _____yes_____no_____not sure

16. When was your last period? _____

17. How many days did it last? _____

18. Do you have, or did you ever have Premenstrual Syndrome (PMS)? _____yes_____no

If yes, explain

symptoms: _____



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19. Do you take Hormone Replacement Therapy? _____yes_____no

If yes, what

kind?_____
