

PHARMACY RX SOLUTIONS

Name of Patient _____ D.O.B. _____ Sex: Male Female

Address _____
Street City/Town State Zip Code

Family Physician _____ Date & Reason Consulted _____

Address _____
Street City/Town State Zip Code

Treatment and/or Medication Prescribed? Yes No (If Yes, give details in #8 Remarks Section)

- | | | |
|--|-----|----|
| | YES | NO |
|--|-----|----|
1. Have you ever consulted any medical practitioner for, or so far as you know, ever been treated for:
 - A. Any disorder of eyes, ears, nose or throat, including speech impairment or loss of sight? YES NO
 - B. Any disease of the lungs or respiratory tract such as tuberculosis, emphysema, pleurisy, asthma, hay fever, spitting blood, or persistent hoarseness or coughing? YES NO
 - C. Any disorder of the heart or blood vessels, e.g., heart attack, angina pectoris, stroke, palpitations, elevated blood pressure, shortness of breath, chest pain, irregular pulse or varicose veins? YES NO
 - D. Any disease of the stomach, liver, intestines or rectum, e.g., ulcers, gallbladder disease, bleeding from intestinal tract, colitis, diverticulitis or appendicitis? YES NO
 - E. Any disorder of the prostate, bladder, kidneys or genito-urinary tract, e.g., nephritis, sugar, protein or pus in urine, venereal disease, kidney stones or colic? YES NO
 - F. Any brain or nervous system disorder, e.g., epilepsy, convulsions, fainting or loss of consciousness, mental illness, constant nervousness or severe headaches? YES NO
 - G. Any alcoholism or excessive use of alcohol or any drug habit? Any treatment or hospitalization? YES NO
 - H. Any impairment of function, or loss of hand, arm, shoulder, foot, leg or hip, or back disorder? YES NO
 - I. Anything else, e.g., cancer, cyst or tumor, blood disorder, hypoglycemia, diabetes, glandular condition, e.g., thyroid, hernia, skin disease or eczema? YES NO
 2. Have you ever:
 - A. Had a surgical operation? YES NO
 - B. Been told to have an operation that wasn't performed? YES NO
 - C. Had any diagnostic procedures, e.g. x-ray, electro-cardiogram? YES NO
 - D. Lived with someone who has had T.B. in the last 2 years? YES NO
 - E. Had a weight change in the past year? If yes, reason? (List below) YES NO
 - F. Had a physical or mental condition that caused you to be deferred, rejected or discharge from the armed forces? YES NO
 - G. Ever applied for or received any pension or benefits for sickness, disability or accident? YES NO

- | | | |
|--|-----|----|
| | YES | NO |
|--|-----|----|
3. Other than previously stated, as far as you know, have you in the last 5 years:
 - A. Had any illness, disease or injury? YES NO
 - B. Been admitted to, or been advised to enter, a hospital or sanitarium, etc. YES NO
 - C. Consulted any medical practitioner for any reason (including check-ups?) YES NO
 - D. Any reason to feel you are not in good health? YES NO
 - E. Are you taking any medication or drugs? YES NO
 4. For women only:
 - A. Are you pregnant? If yes, please give month of pregnancy, any previous pregnancies, and any complications of those pregnancies, if any. (list below) YES NO
 - B. Any disorder of the breasts or female organs? YES NO

5. A. Family History

Family Record	Age If Living	Condition of Health If not "Good," give details	Age At Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

- B. Any family history of diabetes, cancer, hypertension, heart or kidney disease, mental illness or suicide? YES NO
6. Do you participate in regular exercise? If yes, describe type and frequency. (list below) YES NO
7. Smoking Habits:

Do you smoke cigarettes? YES NO

If yes, packs per day (list below)

If non-smoker, did you ever smoke cigarettes? YES NO

If yes, for how long, packs per day and when did you quit? (list below)

8. Remarks: Please give full details for any questions above answered "Yes".

Question #	Dates and Duration	Physician's Name, Hospital or Company, Address, City, State and Zip Code Nature of Condition, Treatment, Results, Reasons and Other Information

9. Pulse _____ per/minute Regular Irregular
Number of Irregularities, if any _____

10. Blood Pressure 1st Reading 2nd Reading 3rd Reading
Systolic _____ _____ _____
Diastolic _____ _____ _____

To be taken at separate intervals and if systolic is 140 or over, or diastolic is 90 or over, repeat after 10 minutes rest.
Then take 2 additional readings.

11. Height _____ (without shoes) Weight _____

12. Measurements (Males Only) 13. Did you weigh? Yes No
Chest at forced expiration _____ Did you measure? Yes No
Chest at full inspiration _____
Abdomen at umbilicus _____

14. Chief complaint (as stated by patient, if any):

15. Remarks:

I HEREBY DECLARE that, to the best of my knowledge and belief, the information given in these answers to the Pharmacy Rx Solutions is correctly recorded, complete and true, and I agree that the Company, believing them to be true, shall rely and act upon them accordingly. This physical exam is required so that our doctors have accurate current health information and that information is then reviewed by our medical staff along with testing results and health histories so that our doctors can properly review, qualify, and treat patients for all preventative health services, HRT, and HCG therapy programs.

Dated at _____ on _____ 20 _____

Signature of Patient _____