Rx³ Compounding Pharmacy
Quality Reliability Integrity Excellence

Phone: 804-717-5000 • Toll Free: 888-384-5470

Chester • Fax: 804-717-8300
12230 Ironbridge Rd., Ste C • Chester VA 23831

Short Pump • Fax: 804-269-4304
11934 West Broad St. • Henrico VA 23233

Confidential Pediatric Health Questionnaire

Please fax (804.269.4304) or email (talonna@rx3pharmacy.com) your completed forms at least 24 hours prior to your appointment, if possible.

General Patient Information

Patient's Name: _____
Nickname / Preferred Name: _____
Date of Birth: _____ Age: _____
Today's Date: _____
Ethnicity: _____

Pediatrician Name: _____
Pediatrician Phone #: _____
Date of last physical exam: _____

Parent/Guardian Name(s): _____
Address: _____
Phone: Home: _____ Cell: _____ Work: _____
Email address: _____ Gender: _____
How do you prefer to be contacted? ____Home ____Cell ____Work ____Email
Is it okay to leave a message? ____Home ____Cell ____Work
Please list any specialists that your child has seen:
Dr.'s Name: _____ Specialty: _____
Dr.'s Name: _____ Specialty: _____

Primary Health Concerns:	*If applicable, please list prior approaches related to your concerns:*		
	Prior Diagnoses	Prior Labs/Imaging	Prior Treatments

What expectations/goals do you have for your first visit to our clinic? _____

_____

What are your long-term goals while working with our clinic? _____

_____

Are there any lifestyle factors (i.e. food, sleep, stress, family dynamics, etc) that you believe may be contributing to your child's health issues?
(please list) _____

To what extent are you open to addressing & changing lifestyle factors that may be contributing to your child's symptoms?
circle: (least open) 1 2 3 4 5 (most open)

When did your child last seem completely well? _____

Any significant events in the 6 months prior to becoming unwell? (mention anything, even if it seems unrelated) _____

_____

Any ideas about what triggered or caused your child's symptoms? _____

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Medications & Supplements

Current Prescriptions, Over-the-Counter Medications, & Supplements (include oral, topical, and suppositories)

Name of Product (Include brand for supplements)	**Date Started**	**Prescribed by** (Dr's name or Self)	**Reason for taking**	**Dosage** (ex. drugs: 100mg, 2 capsules, 1 tsp.)	**Frequency** (ex. 3x/day)	**Has it helped?**

Does your child have a history of extensive antibiotic or steriod use? If Yes, please explain:_____

Please circle the forms of supplements/medications that your child prefers, and put an 'X' through any that he/she definitely do not like:
• No preference • Capsules • Tablets • Liquids • Powders • Tinctures (alcohol-based) • Teas
• My child has difficulty difficulty taking supplements • Other:_____

Past medical History

Allergies & Sensitivities: Please list all substances that your child reacts adversely to (even if the reaction is minor)

	Substance & Type of Reaction (ex: peanuts --> Hives & breathing difficulty)
Food	
Medicines & Supplements	
Environmental (dust, trees, etc)	
Other	

Has your child ever experienced a life-threatening allergic reaction? Y / N If Yes, Please explain: _____

Hospitalizations, Surgeries, & Major Illnesses

Age or Year	**Condition or Procedure**	**Any ongoing problems related to this?**

Immunizations: Please check all vaccinations that your child has received:

- ☐ mmr (measles, mumps, rubella)
- ☐ smallpox
- ☐ H. Influenza
- ☐ tetanus (isolated)
- ☐ other
- ☐ dpt (diphtheria, pertussis, tetanus)
- ☐ measles (isolated)
- ☐ hepatitis B
- ☐ rubella (isolated)
- ☐ chicken pox (varicella)
- ☐ diphtheria (isolated)
- ☐ mumps (isolated)
- ☐ polio

Did your child experience any adverse reactions to any of the above vaccines? Y/N
If yes, please list vaccine(s) and type of reaction:_____

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Family History

Is your child adopted? ☐ yes ☐ no

Please check any health issues experienced by members of your family:

☐ alcoholism/drug Addiction	☐ autoimmune Disease	☐ depression	☐ learning disability	☐ allergies
☐ bleeding disorder	☐ diabetes	☐ mental illness	☐ arthritis	☐ cancer
☐ heart disease	☐ tuberculosis	☐ asthma	☐ celiac disease	☐ high blood pressure

Do any other significant medical conditions or symptoms run in, or are present in, your family?

_____

Please list the members of your household, including ages of any other children:

_____

Do you have any family pets? Please list:_____

Review of Symptoms

Please Circle As Follows: ***Y= a condition you have now,*** ***P= a condition you had in the past,*** *(note: for past problems, only circle if they were significant. For example, everyone has had a cough due to a cold, so you don't need to circle this unless it was significant or recurrent).*

General
Weight _____
Height _____
Fatigue Y P
Fever / Chills Y P
Night Sweats Y P

Skin & Hair
Eczema Y P
Psoriasis Y P
Rashes / Hives Y P
Hair Loss Y P
Itching Y P
Dandruff Y P
Lice Y P
White Spots on Nails Y P
Ridges on Nails Y P

Head / Eyes / Ears
Headaches Y P
Head Injury Y P
Impaired Vision Y P
Dark circles under eyes Y P
Impaired Hearing Y P
Ear infections Y P
Excessive ear wax Y P
Ringing Ears Y P
Earaches Y P

Musculoskeletal
Joint pain/swelling Y P
Broken Bones Y P
Muscle pain/cramps Y P
Scoliosis Y P
Trauma /accident Y P

Nose/Sinuses/Mouth
Frequent colds Y P
Nose bleeds Y P
Stuffiness Y P
Sinus problems Y P
Seasonal allergies (hayfever) Y P
Frequent sore throat Y P
Teething Pain Y P
Cold Sores Y P
Dental Cavities Y P
# of amalgam fillings _____
Thrush Y P

Respiratory / Throat
Cough Y P
Wheezing Y P
Asthma Y P
Bronchitis Y P
Pneumonia Y P
Croup Y P
Strep throat Y P
Tonsillitis Y P

Cardiovascular
Heart murmur Y P
Rheumatic Fever Y P

Miscellaneous:
Scarlet fever Y P
Roseola Y P
Chicken pox Y P
Anemia Y P
Easy bruising Y P
Bleeding tendency Y P

Gastrointestinal
Nausea/vomiting Y P
Abdominal Pain / colic Y P
Flatulence / belching Y P
Jaundice Y P
Anal itching Y P
Diaper Rash Y P
Constipation Y P
Loose Stools/Diarrhea Y P
Straining with BM Y P
Blood or Mucous in stool Y P
BM per day _____
Excessive thirst / hunger Y P
Loss of appetite Y P

Genitourinary
Bed wetting Y P
Urinary tract infection Y P
Burning/difficult urination Y P
Kidney disease Y P
Blood in urine Y P
(F) Yeast infections Y P
(M) Undescended testicles Y P

Mental/Emotional
Insomnia / sleep issues Y P
Anxiety Y P
Nightmares Y P
Behavioral Disorder Y P

Neurological
Dizzy spells Y P
Seizures Y P
Motor Problems Y P

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Prenatal & Birth History

Prenatal History

Mother's age at child's birth: _____
Mother's health during pregnancy: (check any health issues that were present)

- ☐ bleeding
- ☐ nausea
- ☐ stress and anxiety
- ☐ illnesses: _____
- ☐ high blood pressure
- ☐ cigarette, alcohol, drug consumption
- ☐ strep B
- ☐ thyroid problems
- ☐ medications: _____
- ☐ diabetes
- ☐ physical or emotional trauma
- ☐ other: _____
- ☐ Rh incompatibility

Birth History

Term: full / premature / late Height at birth: _____ Weight at birth: _____ Length of Labor: _____
Complications? _____ Please check: ☐ vaginal birth ☐ c-section

Did your child have any of the following after birth? Please check

- ☐ rashes
- ☐ blue baby
- ☐ colic
- ☐ birth injuries
- ☐ fever
- ☐ difficult feeding
- ☐ seizures
- ☐ cerebral palsy
- ☐ Other: _____

Age began: sitting _____ crawling _____ talking _____ walking _____

Nutrition

Is/was your child: ☐ breastfed ☐ formula-fed ☐ both What type of formula? ☐ milk ☐ soy ☐ other: _____
At what age was food introduced? _____
Please list approximate age that your child started consuming the following foods (if applicable):

Vegetables: _____ Meat, Poultry, Fish: _____ Beans/Legumes: _____
Fruits:: _____ Dairy: _____ Fruit Juice: _____
Grains (rice, oats, etc): _____ Sweets: _____ Soda: _____

How often does your child consume the following? 0=never, 1=rarely (1-4x/month), 2=often (2-4x/week), 3=regularly (5-7x/week)

Water	____ cups/day			White flour (bread, pastry)	0	1	2	3	Milk, cream	0	1	2	3
Soda	0	1	2	3	White Rice	0	1	2	3	Yogurt	0	1	2	3
Fruit Juice	0	1	2	3	Whole Grains & Brown Rice	0	1	2	3	Cheese	0	1	2	3
Fruit	0	1	2	3	Fish	0	1	2	3	Eggs	0	1	2	3
Vegetables	0	1	2	3	Poultry	0	1	2	3	Chocolate	0	1	2	3
Legumes, beans	0	1	2	3	Red Meat	0	1	2	3	Sweets (candy, cookies, cake)	0	1	2	3
Nuts/Seeds	0	1	2	3	Unfermented soy (soy milk)	0	1	2	3	Salty Snacks (chips, pretzels)	0	1	2	3
Fast food (fried)	0	1	2	3	Fermented soy (tofu, tempeh)	0	1	2	3	Artificial Sweeteners*	0	1	2	3
Fast food (lighter choices)	0	1	2	3									

Please list typical meals/foods consumed throughout the day:

Breakfast:	Dinner:
Lunch:	Snacks:
Food Aversions	Food Cravings

How would you describe your child's personality/disposition? _____
Is there anything else you would like me to know about your child? _____