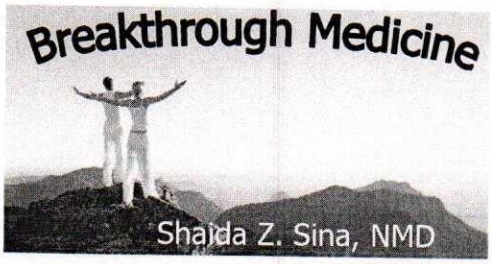


Practice: 702 S. Main Street
Cottonwood, AZ 86326
Phone: (928) 649 – 0269
Fax: (866) 644 – 6363
office@breakthroughmed.com

EMERGENCY RX REFILL

PATIENT NAME:(PLEASE PRINT) _____ DATE: _____

LIST EACH **PRESCRIPTION** AND THE **NAME OF PHARMACY** WHERE THE PRESCRIPTION MUST BE SENT:

1._____ 2. _____ 3._____

4._____ 5._____ 6._____

ANY CHANGE IN YOUR HEALTH SINCE LAST VISIT?

IF "YES", PLEASE EXPLAIN:_____

_____

THIS COULD BE A NEW CONDITION, MAJOR LIFE CHANGE (DIVORCE, FAMILY DEATH…) OR CHANGE IN OLD CONDITIONS:

_____

_____

HAVE YOU GONE TO URGENT CARE, THE EMERGENCY ROOM OR BEEN HOSPITALIZED SINCE OUR LAST VISIT?

CIRCLE: YES OR NO. PLEASE LIST:_____

IF YES PLEASE EXPLAIN:_____

PLEASE LIST ALL CURRENT MEDICATIONS AND NOTE ANY CHANGES SINCE YOUR LAST VISIT:

1)_____

2)_____

3)_____

4)_____

5)_____

6)_____

PLEASE LIST SUPPLEMENTS AND HOW YOU ARE TAKING THEM:

1)_____

2)_____

3)_____

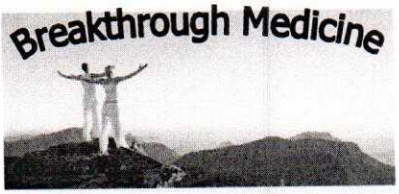
4)_____

5)_____

6)_____

7)_____

8)_____



Patient Visit Location: 702 S. Main Street
Cottonwood, AZ 86326

ERX Update

HEALTH PROFILE

NAME _____ DATE_____

Rate each of the following symptoms upon your typical health profile for:

Point Scale	
0	*Never* or *Almost never* have the symptom
1	*Occasionally* have it, effect is *not severe*
2	*Occasionally* have it, effect is *severe*
3	*Frequently* have it, effect is *not severe*
4	*Frequently* have it, effect is *severe*

Head	____	Headaches
	____	Faintness
	____	Dizziness
	____	Insomnia
	____	TOTAL
Eyes	____	Watery or itchy eyes
	____	Swollen, reddened or sticky eyelids
	____	Bags or dark circles under eyes
	____	Unusual blurred or tunnel vision
	____	TOTAL
Ears	____	Itchy ears
	____	Earaches, ear infections
	____	Drainage from ear
	____	Ringing in ears, hearing loss
	____	TOTAL
Nose	____	Stuffy nose
	____	Sinus problems
	____	Hay fever
	____	Sneezing attacks
	____	Excessive mucous formation
	____	TOTAL
Mouth Throat	____	Chronic coughing
	____	Gagging, freq. Need to clear throat
	____	Sore throat, hoarseness, loss of voice
	____	Swollen or discolored tongue, gums, lips
	____	Canker sores
	____	TOTAL
Skin	____	Acne
	____	Hives, rashes, dry skin
	____	Hair loss
	____	Flushing, hot flashes
	____	Excessive sweating
	____	TOTAL
Heart	____	Irregular or skipped heart beat
	____	Rapid or pounding heartbeat
	____	Chest pain
	____	TOTAL
Lungs	____	Chest congestion
	____	Asthma, bronchitis
	____	Shortness of breath
	____	Difficulty breathing
	____	TOTAL
Digestive Tract	____	Nausea, vomiting
	____	Diarrhea
	____	Constipation
	____	Bloated feeling
	____	Belching, passing gas
	____	Heartburn
	____	Intestinal / stomach pain
	____	TOTAL
Joints/ Muscles	____	Pain or aches in joints
	____	Arthritis
	____	Stiffness /limitation of movement
	____	Pain or aches in muscles
	____	Feeling of weakness or tiredness
	____	TOTAL
Weight	____	Binge eating/drinking
	____	Craving certain foods
	____	Excessive weight
	____	Compulsive eating
	____	Water retention
	____	Underweight
	____	TOTAL
Energy/ Activity	____	Fatigue, sluggishness
	____	Apathy, lethargy
	____	Hyperactivity
	____	Restlessness
	____	TOTAL
Mind	____	Poor memory
	____	Confusion, poor comprehension
	____	Poor concentration
	____	Poor physical coordination
	____	Difficulty in making decisions
	____	Stuttering or stammering
	____	Slurred speech
	____	Learning disabilities
	____	TOTAL
Emotions	____	Mood swings
	____	Anxiety, fear, nervousness
	____	Anger, irritability, aggressiveness
	____	Depression
	____	TOTAL
Other	____	Frequent illness
	____	Frequent or urgent urination
	____	Genital itch or discharge
	____	TOTAL

HEALTH PROFILE GRAND TOTAL _____

FEMALE HORMONE SURVEY

Please score: BLANK= No Symptoms.
USE 1-5 (1=Mild 5=Severe)

Hot Flashes	____
Night Sweats	____
Irritability	____
Mood Swings	____
Weepy	____
Irregular Periods	____
Heavy Periods	____
Bleeding between periods	____
Low sex drive	____
Lumpy breasts	____
Unable to reach orgasm	____
Painful intercourse	____
Lack of vaginal lubrication	____
Breast tenderness	____
Drooping breasts	____
Sleep problems	____
Anxiety or panic attacks	____
Depression	____
Loss of motivation	____
Feeling apathetic	____
Fatigue	____
Memory loss	____
Thinning hair	____
Dry skin	____
Cellulite	____
Decreased muscle strength	____
Fluid retention	____
Headache	____
Joint pain	____
Muscle pain	____
Urinary incontinence	____
Acne	____
Facial hair growth	____
Constipation	____
Food Cravings	____
Vaginal Discharge	____
Vaginal Itching	____

HORMONE SURVEY TOTAL

_____

Ph: 928.649.0269 FAX: 866.644.6363 Email: office@breakthroughmed.com