wholesome health
PHARMACY

2069 N. Barrington Rd.
Hoffman Estates, IL 60169
224.653.9878

Patient Information	**List your five major health concerns in order of importance**
Patient Name: Date of Birth: Phone Number: ( ) - Email: Address: Occupation: Marital Status: ☐ single ☐ married ☐ divorced ☐ widowed	1. 2. 3. 4. 5.
List any prescribed & OTC medications currently taking ☐ Unknown ☐ None	**List any supplements, vitamins, botanicals, or homeopathics currently taking** ☐ Unknown ☐ None
Any known medical conditions ☐ Unknown ☐ None	**Allergies/Sensitivities/Intolerances** ☐ Unknown ☐ None
Important past medical conditions (ex. surgeries/injuries) please indicate when	**Stress Levels** Least ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ Most Scale from 1-10

Wellness Specialist:
Date reviewed:

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BLOOD SUGAR

Have you been told by a doctor that you are insulin resistant, pre-diabetic, or diabetic?..... ☐ yes ☐ no

Do you feel irritable if a meal is missed or get headaches, feel anxious/nervous/shaky if you go more than 4 hours without eating?..... ☐ yes ☐ no

Crave sweets or coffee in afternoon or mid-morning..... ☐ yes ☐ no

Do you crave carbohydrates (breads, pasta, crackers)?..... ☐ yes ☐ no

Do you get energy crashes during the day? ☐ yes ☐ no..... **IF YES**, are they relieved by caffeine or food? ☐ yes ☐ no

Are you more than 20 pounds your ideal body weight?..... ☐ yes ☐ no

Do you have night sweats?..... ☐ yes ☐ no

Is your memory, concentration, or focus poor?..... ☐ yes ☐ no

Do you get tired after eating a big meal?..... ☐ yes ☐ no

Any other issues concerning your blood sugar?

THYROID

Do you feel exhausted and tired from morning to night? ..... ☐ yes ☐ no

Do you have trouble waking up in the morning? ..... ☐ yes ☐ no

Do you have dry skin, brittle hair/nails? ..... ☐ yes ☐ no

Do you have cold hands/feet? ..... ☐ yes ☐ no

Are your eyebrows thinning (especially around the edges)? ..... ☐ yes ☐ no

Is your hair ☐ thinning **OR** ☐ course or dry..... ☐ no

Do you have a history of heart palpitations? ☐ yes ☐ no.....**If YES**, ☐ Abnormally rapid **OR** ☐ Irregular heart beat

Do your hands shake or tremble? ..... ☐ yes ☐ no

Do you have difficulty ☐ losing **OR** ☐ gaining weight? ..... ☐ no

Do you have high energy levels, followed by exhaustion or extreme tiredness? ..... ☐ yes ☐ no

Any other issues concerning the thyroid?

Wellness Specialist:
Date reviewed:

STOMACH

Have you ever taken antibiotics for long periods of time (more than a week at a time)?..... ☐ yes ☐ no

IF YES, how long ago

Have you had or do you get ☐ skin rashes **OR** ☐ eczema?..... ☐ no

Have you been diagnosed with ☐ ulcer **OR** ☐ GERD (acid reflux)?..... ☐ no

Do you get gassy or bloated easily, especially after eating a meal?..... ☐ yes ☐ no

Do you feel full for extended periods of time after eating?..... ☐ yes ☐ no

Do you have stomach pains before or after eating?..... ☐ yes ☐ no

IF YES, does it get worse with stress or emotional upset? ☐ yes ☐ no

Do you have frequent ☐ constipation **OR** ☐ diarrhea **OR** ☐ go back and forth between the two?..... ☐ no

Are your bowel movements painful or difficult to pass?..... ☐ yes ☐ no

Is there visible ☐ blood **OR** ☐ undigested foods in your stools..... ☐ no

Any other issues concerning the stomach?

CARDIOVASCULAR

Have you been told you have ☐ high blood pressure **OR** ☐ high cholesterol?..... ☐ no

Do you exercise regularly? ..... ☐ yes ☐ no

Do you feel out of breath after walking up a flight of stairs?..... ☐ yes ☐ no

Do you have swelling in your feet and/or ankles? ..... ☐ yes ☐ no

Do you experience any ☐ chest pain? ☐ During physical activity? ☐ At rest? ..... ☐ no

Do you have difficulty breathing at night? ..... ☐ yes ☐ no

Do your calf muscles cramp while walking or do you experience restless leg syndrome at night?..... ☐ yes ☐ no

Do you get ☐ light-headed easily **AND/OR** ☐ faint? ..... ☐ no

Any other issues concerning cardiovascular health?

ADRENALS

Are you easily irritated?..... ☐ yes ☐ no

In a day, how much coffee do you drink? Tea? ..... ☐ none

Do you recover poorly from injury or illness? ..... ☐ yes ☐ no

Has your ability or want to exercise decreased?..... ☐ yes ☐ no

Do you have enough energy to get you through the day? ..... ☐ yes ☐ no

Anything else you want to tell us about your energy levels?

LUNGS

Do you have ☐ difficulty breathing **AND/OR** ☐ shortness of breath? ☐ no

Do you get chest pain with deep breaths? ☐ yes ☐ no

Is there rattling in your lungs when you breathe? ☐ yes ☐ no

Do you have a history of ☐ bronchitis **OR** ☐ asthma? ☐ no

Do you ☐ smoke **AND/OR** ☐ live around people that smoke? ☐ no

Have you ever been exposed to asbestos? ☐ yes ☐ no ☐ unsure

Do you live in an industrialized area with a large amount of pollution? ☐ yes ☐ no

Any other issues concerning lung health?

SLEEP

How many hours a night of sleep do you get?

Are you a restless sleeper and awaken during the night? ☐ yes ☐ no

Do you have difficulty falling asleep? ☐ yes ☐ no…… **IF YES**, is it due to ☐ anxiety **OR** ☐ replaying events over and over?
IF neither, please explain

When you wake up in the morning, do you feel energized and ready for the day? ☐ yes ☐ no

Do you snore to the point that other people comment? ☐ yes ☐ no

Do you have a history of sleep apnea? ☐ yes ☐ no

Do you have nightmares? ☐ yes ☐ no

Do you have night sweats? ☐ yes ☐ no

Any other issues concerning sleeping habits?

LIVER

Are you intolerant of greasy foods (ex. fried foods or fatty meats)? ☐ yes ☐ no

Do you have pain or discomfort on your right side under your rib cage? ☐ yes ☐ no

Do you have a light colored or yellowish stool? ☐ yes ☐ no

Are the whites of your eyes yellowed? ☐ yes ☐ no

Do you have a sour taste in your mouth often? ☐ yes ☐ no

Do you have bad breath? ☐ yes ☐ no

Do you have excessive body odor? ☐ yes ☐ no

How much alcohol do you consume in a week? Please explain

GENITOURINARY

Do you have pain or burning when urinating?..... ☐ yes ☐ no

Do you have frequent urination not related to the amount of liquids consumed? ..... ☐ yes ☐ no

Do you have cloudy urine?..... ☐ yes ☐ no

Do you have difficulty holding your urine?..... ☐ yes ☐ no

Have you had a history of ☐ urinary tract infections **AND/OR** ☐ cystitis?..... ☐ no

Any other concerns or issues with the kidneys?

FEMALE QUESTIONS ONLY

Itching..... ☐ yes ☐ no

Discharge..... ☐ yes ☐ no

Vaginal dryness ..... ☐ yes ☐ no

Sexual dysfunction..... ☐ yes ☐ no

Painful intercourse..... ☐ yes ☐ no

Tender breasts ..... ☐ yes ☐ no

Recurring yeast infections..... ☐ yes ☐ no

Diagnosed with uterine fibroids..... ☐ yes ☐ no

☐ Regular **OR** ☐ Irregular menstrual cycles **OR** ☐ Post-menopausal?

IF NOT POST-MENOPAUSAL, do you experience PMS symptoms ☐ yes ☐ no
IF YES, please describe

MALE QUESTIONS ONLY

Hesitancy..... ☐ yes ☐ no

Dribbling..... ☐ yes ☐ no

Decreased stream..... ☐ yes ☐ no

Testicular pain..... ☐ yes ☐ no

Testicular mass..... ☐ yes ☐ no

Penile discharge..... ☐ yes ☐ no

Decreased libido..... ☐ yes ☐ no

Erectile dysfunction..... ☐ yes ☐ no

Painful intercourse..... ☐ yes ☐ no

Lastly, please indicate typical foods eaten in a normal 24 hours period, including any snacks and beverages.

Breakfast:

Snack:

Lunch:

Snack:

Dinner:

Snack:

How many glasses of water are usually consumed in a day?

Thank you for taking the time to fill out this questionnaire about your health. This will give your wellness specialist a better idea of your health state and current chief complaints. In addition, this information will help guide us for a more tailored approach to your health and wellbeing. We are here to answer your questions and educate you on information you may or may not know about your health. If we do not know the answer off hand, we are open to doing the research in order to give you the most up to date answer possible.

X_____

(signature)

By signing here, you are acknowledging that

****this is not meant to substitute for a physician consultation. Always consult with your physician before making any modification or alteration to medication regimen.****

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