

Patient Name: _____ Date of Birth: _____ Date of Visit: _____
 Cell Phone #: _____ Home Phone #: _____
 Email: _____ Can we correspond by email and phone? Y N
 Emergency Contact Phone #: _____ How did you hear about us? _____

1. What is your main complaint or problem? (if your health is good and you are looking for wellness/prevention medicine, please skip to section 2)

Please give a brief description of your problem (specifically include when it began, what caused it, if known and what is happening currently):

List other problems you would like to address:

What was your health like before problems began?

2. LIFESTYLE:

SMOKING

- No tobacco use
- 1 pack/day
- 2 packs/day
- <2 packs/day

ALCOHOL

- No alcohol use
- Positive alcohol consumption
 - Rarely
 - Socially
 - Daily
 - Current alcoholic
 - Recovering alcoholic

EXERCISE

- No regular exercise program
- Exercises 1-2 times per week
- Exercises 3-4 times per week
- Exercises 5-6 times per week
- Exercises daily – how many hours per day? _____

SLEEP (check all that apply)

- I sleep good usually about _____ hrs per night
- I sleep good most nights but do have some trouble from time to time
- I fall asleep fine but wake up throughout the night
- I have trouble falling asleep
- I have trouble both falling asleep and staying asleep
- I DO NOT feel rested even if I think I slept well

STRESS

- I have very little stress in my life
- I have some stress in my life
- My life is stressful most days
- I deal with the stress in my life very well
- I sometimes struggle with how to deal with the stress in my life
- I am not doing very well in dealing with the stress in my life

I DO THE FOLLOWING TO HELP WITH MY STRESS (check all that apply)

- Exercise
- Meditate or pray
- Use breathing techniques
- Do biofeedback
- Take medication

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DIET

- What is a typical breakfast? _____
- What is a typical lunch? _____
- What is a typical dinner? _____
- What is a typical snack and how often do you consume them? _____
- What type of foods do you crave? (ie salty, carbohydrates, sweets or proteins etc) _____

3. Please check any major medical problems that you have or have had in the past:

- No major medical problems

HEART PROBLEMS

- Coronary artery disease
(heart attack, angina)
- Hypertension (high blood pressure)
- Cardiac arrhythmia
- Heart murmur
- Hypercholesterolemia
(cholesterol problems)

STOMACH PROBLEMS

- Chronic or intermittent diarrhea
- Constipation
- Reflux disease (GERDS)
- Abdominal pain/bloating/cramping
- Gallbladder problems
- Hepatitis
- Cirrhosis

AUTOIMMUNE/IMMUNE PROBLEMS

- Systemic Lupus
- Multiple Sclerosis
- Chronic Fatigue Syndrome
- Fibromyalgia
- Hypothyroidism
- Hyperthyroidism
- Chronic or recurrent yeast infections

LUNG/RESPIRATORY PROBLEMS

- Chronic or recurrent sinusitis
- Chronic or recurrent upper respiratory infections
- Seasonal allergies
- Asthma
- Chronic obstructive pulmonary disease
(COPD/emphysema)

JOINT/BONE PROBLEMS

- Osteoporosis
- Degenerative joint disease
- Osteoarthritis
- Rheumatoid arthritis

URINARY PROBLEMS

- Chronic or recurrent urinary tract infections
- Kidney stones
- Prostate problems (male only)
- Renal disease
- Urinary incontinence

BLOOD PROBLEMS

- Anemia
- HIV

NUTRITIONAL PROBLEMS

- Vitamin B12 deficiency
- Diabetes
- Glucose intolerance
- Vitamin D deficiency

SKIN PROBLEMS

- Chronic or recurrent rash
- Psoriasis
- Excessive hair growth
- Hair loss

MENTAL HEALTH PROBLEMS

- Depression
- Anxiety
- Bipolar Disorder
- Schizophrenia
- Alcoholism

CANCER

- Breast cancer
- Prostate cancer
- Leukemia/Lymphoma
- Others _____

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4. Please list any over-the-counter medications and/or any supplements that you are taking:

Name of supplement	Dosage	How often do you take your supplement?	Regularly	As needed

5. Please list any allergies to medications or foods?

Do you have increased sensitivities to things in your environment like perfumes, chemicals etc?

6. Please list your current medications (do not include any hormones):

Name of medication	Dosage	How often do you take your medication?	Regularly	As needed

7. Past medications tried and why you stopped taking them (do not include any hormones):

Name of medication	Dosage	How often was the medication taken?	Why did you stop taking it

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Please check:

8. Past surgeries (what year was your surgery):

- No prior surgeries _____
- Tonsils removed _____
- Appendix removed _____
- Gallbladder removed _____
- Hysterectomy _____
- Disectomy _____
- Spinal fusion _____
- Skin lesions removed _____
- Breast lumps removed _____
- Other _____

9. Diseases in your family (include what family member has each disease):

- High blood pressure _____
- Heart disease _____
- Strokes _____
- High cholesterol _____
- Diabetes _____
- Thyroid disease _____
- Arthritis of the spine _____
- Arthritis of joints _____
- Thinning of bones _____
- Breast cancer _____
- Colon cancer _____
- Prostate cancer _____
- Lung cancer _____
- Other _____

10. Occupational History:

What is your current or most current occupation? _____

How much do you like your work on a scale of 1 to 5 (1=very little, 5=very much): _____

- Are you:** Employed (how many hours per week do you work? _____) On disability (started when? _____)
- Unemployed Retired

Does your health affect your ability to perform duties at work? Explain: _____

Does your health interfere with your ability to enjoy hobbies and social activities? Explain: _____

11. Is there anything else about your medical history that we should know? _____

MALE HORMONE EVALUATION

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Please rank the severity of each symptom listed below

0 = no symptoms

10 = very severe symptoms

LOW TESTOSTERONE

SEXUAL FUNCTION

- Decrease in spontaneous AM erections
- Decreased sex drive
- Decrease in fullness of erections
- Decrease in volume of ejaculate or semen
- Decrease in strength of climax or force of musculature pulsation
- Difficulty in maintaining full erection
- Difficulty in starting erection – or no erection
- Unexplained weight gain, particularly in the midsection
- Increased fat distribution in breast area or hips
- Development on chest pain/heart disease
- Shortness of breath with activities or worsening of asthma or emphysema
- Lightheadedness, dizzy spells
- Ringing of the ears
- Change in vision
- Poor circulation in legs, swelling of ankles, varicose veins, hemorrhoids

MENTAL FUNCTION

- Mental fatigue or inability to concentrate
- Tiredness or sleepiness in the afternoon or early evening
- Decrease in mental sharpness
- Change in creativity or spontaneous new ideas
- Decrease in the initiative or desire to start new projects
- Decreased interest in past hobbies
- Decrease in competitiveness
- Increased forgetfulness
- Feeling of depression; a sense that work, marriage or recreational activities have lost significance

MUSCULOSKELETAL CONDITION

- "Sore-Body Syndrome" – joint and muscle pains
- Decline in flexibility and mobility
- Decrease in muscle size, tone, strength
- Decrease in physical stamina
- Decrease in athletic performance
- Back pain; neck pain
- Tendency to pull muscles or get leg cramps
- Development of osteoporosis

METABOLIC OR PHYSICAL PROBLEMS

- Increase in total cholesterol or triglycerides
- Decrease in HDL levels
- Rise in blood sugar level or diabetes onset
- New onset headaches

LOW THYROID

- All Day fatigue
- Dry skin
- Dry, brittle hair
- Hair loss
- Weight gain
- Depression
- Lack of interest (apathy)
- Loss of enjoyment
- Difficulty focusing
- Carbohydrate craving
- Constipation
- Cold intolerance
- Depression

LOW CORTISOL

- Fatigue (morning and afternoon)
- Difficulty concentrating
- Sleep disturbances
- Memory problems
- Depression
- Dry Skin
- Irritability