



### Surgeries/Hospitalizations

| Type of Surgery / Hospitalization | Date |
|-----------------------------------|------|
|                                   |      |
|                                   |      |
|                                   |      |
|                                   |      |
|                                   |      |
|                                   |      |
|                                   |      |
|                                   |      |

### Medical Information

How would you rate your overall health?  Excellent  Good  Fair  Poor

List any vaccines you've had in the last year:

Allergies:

### Medical History

Please check any condition you currently have OR have ever had in the past (include childhood illnesses).

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> None                   | <input type="checkbox"/> Low Testosterone         | <input type="checkbox"/> Low Blood Pressure  |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Decreased Hormone Levels | <input type="checkbox"/> Fibromyalgia        |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Anxiety                  | <input type="checkbox"/> Pacemaker           |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Gout                     | <input type="checkbox"/> Heart Problem       |
| <input type="checkbox"/> Blood Clot             | <input type="checkbox"/> Seizures                 | <input type="checkbox"/> Infectious Disease  |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> Alcoholism          |
| <input type="checkbox"/> Depression             | <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Sleep Problems      |
| <input type="checkbox"/> Osteoporosis           | <input type="checkbox"/> Concussion               | <input type="checkbox"/> Leg Swelling        |
| <input type="checkbox"/> Pins or Metal Implants | <input type="checkbox"/> STD                      | <input type="checkbox"/> Breathing Problems  |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Hernia                   | <input type="checkbox"/> Migraines/Headaches |
| <input type="checkbox"/> Epilepsy               | <input type="checkbox"/> Visual Dysfunction       | <input type="checkbox"/> Thyroid Trouble     |
| <input type="checkbox"/> COPD                   | <input type="checkbox"/> Neurologic Disorder      | <input type="checkbox"/> Lupus               |
| <input type="checkbox"/> Low Libido             | <input type="checkbox"/> Sinus Problems           | <input type="checkbox"/> Ulcers              |
|   | <input type="checkbox"/> Stomach Problems         | <input type="checkbox"/> High Blood Pressure |

Additional Information of family history and/or other illnesses (Thyroid Disease, Cancer, etc.):

Have you experienced any of these symptoms recently? (Check all that apply)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Chest Pain                   | <input type="checkbox"/> Dizziness                        | <input type="checkbox"/> Fever/Chills/Sweats          |
| <input type="checkbox"/> Pain with Meals              | <input type="checkbox"/> Vision Changes                   | <input type="checkbox"/> Difficulty Speaking          |
| <input type="checkbox"/> Nausea/Vomiting              | <input type="checkbox"/> Memory Problems                  | <input type="checkbox"/> Numbness/Tingling            |
| <input type="checkbox"/> Poor Balance/Falls           | <input type="checkbox"/> Unusual Weakness                 | <input type="checkbox"/> Change in Appetite           |
| <input type="checkbox"/> Difficulty Swallowing        | <input type="checkbox"/> Shortness of Breath              | <input type="checkbox"/> Confusion/Brain Fog          |
| <input type="checkbox"/> Unusual Pain w/Menstruation  | <input type="checkbox"/> Change in Bowel Habits/Control   | <input type="checkbox"/> Increased Pain at Night/Rest |
| <input type="checkbox"/> Unexplained Weight Gain/Loss | <input type="checkbox"/> Change in Bladder Habits/Control | <input type="checkbox"/> Other:                       |
| <input type="checkbox"/> Self-Injury                  | <input type="checkbox"/> Suicidal Ideation                |   |

Women's Health History

Pregnancy Complications:

Date of Last Menstrual Cycle:

Possibly Pregnant:  Yes  No

Number of Pregnancies:

Number of Live Births:

Age of Menopause:

Lifestyle

**Tobacco Use:**  Yes  No

If yes, packs per day:

Number of Years:

Have you ever stopped?  Yes  No

If so, for how long?

**Alcohol Use:**  Yes  No

If yes, drinks per day/week:

Beer  Wine  Liquor

Have you been told you're drinking is a concern?

Yes  No

**Drug Use:**  Yes  No

Marijuana:  Yes  No

Ever used needles:  Yes  No

Notes:

**Diet:**  Balanced  Vegetarian  Diabetic  Low Carb  Low Fat  Low Salt

How would you rate your diet?  Good  Fair  Poor

Would you like nutritional advice?  Yes  No

**Exercise:** Do you exercise regularly?

Yes  No

What kind of exercise?

Duration:

Frequency:

**Sleep:** How many hours, on average do you sleep a night?

Trouble falling asleep?  Yes  No

Trouble staying asleep?  Yes  No

Additional information or concerns you would like to address with us:

By my signature below, I certify that the information I have provided above is complete, accurate and truthful to the best of my knowledge.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Date