Welcome

Patient Medical History

(This Information is protected by the Health Insurance Portability and Accountability Act)

Name: ____ **D.O.B.**_____________ Sex: ☐ M ☐ F

Address: ____City__________________ State_______Zip code: ________

Phone: ____ Email: ____

Reason For Visit: ☐ Weight Management ☐ Stress Management ☐ Menopause Support ☐ Low Testosterone Support
Do you have a Primary Care Provider? Yes ___no ___ Provider's Name_________________________ Phone #_______________
Daily Medications: (Name and Dosage, please include vitamins, nutritional supplements, and diet pills)

____

____

Last Menstrual Period: __/___/____

Drug Allergies: ☐ Yes ☐ No If yes, Name & Type of Reaction: ____

____

Previous Surgery (Type & Date): ☐ Gastric By-pass _________☐ Other: ____

PLEASE PLACE A CHECK MARK NEXT TO ANY DEVICE OR ITEMS THAT YOU HAVE:

☐Cardiac (heart) Pacemaker ☐ Aneurysm clip in brain ☐ Neurostimulator ☐ Dental Magnet

☐Coronary Artery (heart) stent ☐ Implanted heart defibrillator ☐ Bullets, shrapnel or bullet fragments

☐ Rods or screws in joint or back

I DO NOT HAVE ANY OF THE ABOVE ITEMS. (PLEASE INITIAL) ☐

Past Medical History: Please check YES or NO	**Yourself**	**Family Members**	**Relationship**
Heart Disease (heart attack, heart failure abnormal rhythm)	Yes ___ no ___	Yes ___ no ___	______________
Mitral Valve Prolapse	Yes ___ no ___	Yes ___ no ___	______________
Asthma	Yes ___ no ___	Yes ___ no ___	______________
Diabetes - Type 1 or 2 (please circle)	Yes ___ no ___	Yes ___ no ___	______________
High blood pressure (Hypertension)	Yes ___ no ___	Yes ___ no ___	______________
Coronary Artery Disease	Yes ___ no ___	Yes ___ no ___	______________
Seizures	Yes ___ no ___	Yes ___ no ___	______________
Deep Vein Thrombosis/Pulmonary Embolism	Yes ___ no ___	Yes ___ no ___	______________
Glaucoma	Yes ___ no ___	Yes ___ no ___	______________
Erectile Dysfunction	Yes ___ no ___	Yes ___ no ___	______________
Polycystic Ovarian Syndrome (PCOS)	Yes ___ no ___	Yes ___ no ___	______________
Obstructive Sleep Apnea	Yes ___ no ___	Yes ___ no ___	______________
Bipolar____Stable ____unstable	Yes ___ no ___	Yes ___ no ___	______________
Arthritis (OA, RA)	Yes ___ no ___	Yes ___ no ___	______________
HIV	Yes ___ no ___	Yes ___ no ___	______________

SOCIAL/LIFESTYLE HISTORY

Are you an ex-smoker? Yes ___ no ___ Are you a current smoker? Yes ___no ___ If yes, how many cigarettes per day? _____

Do you drink alcoholic beverages? Yes ___ no ___ If yes, how much? ____ _______

Do you have a history of alcohol abuse? Yes ___ no ___ If yes, please describe: ____________________________________

Tell us how you heard about us: ○ Internet ○Flyer/postcard ○ Friend/Family member ○Doctor's office ○Facebook ○Twitter ○Other_____________________

I attest that information provided is correct, complete and current, realizing that the medical care provided to me is based on this information. ___________________________ **Date:** ________________

Signature Required