Patient Information Form

We realize this medical history form is somewhat long. However, it is absolutely necessary for us to evaluate your general health and safely and legitimately prescribe the medications you want and need. Make sure to take a few minutes to carefully and completely answer every question. Failing to do so will prevent us from helping you, as doing so could possibly jeopardize your health. Do the best you can—we will follow-up with any questions we may have. Remember, this information is completely confidential.

I am a (check one) ____ New / ____ Existing patient.

PERSONAL INFORMATION

Full Legal Name: _____
LAST FIRST MIDDLE

Mailing Address: _____
NUMBER STREET UNIT

_____
CITY STATE ZIP

Phone: (___)_____ Email: _____

Date of Birth: _____ Age: _____

Marital Status (check): ____ Married; ____ Divorced; ____ In a committed relationship; ____ Single

Age of all children in home: _____

Gender (check): ____ Male; ____ Female Height: _____ Weight: _____

Occupation: _____ Employer: _____

Primary Physician or clinic:_____ Date of last physical exam: _____

PAST MEDICAL HISTORY

Please indicate if you have, or have ever had, one of the following:

Currently Have	Previously Had		Currently Have	Previously Had	
_____	_____	Anemia	_____	_____	Hepatitis
_____	_____	Arthritis	_____	_____	Heart disease
_____	_____	Asthma	_____	_____	High blood pressure
_____	_____	Blood disease	_____	_____	High cholesterol
_____	_____	Bronchitis	_____	_____	Kidney disease
_____	_____	Diabetes	_____	_____	Migraines
_____	_____	Emphysema	_____	_____	Mononucleosis
_____	_____	Epilepsy	_____	_____	Pneumonia
_____	_____	Gout	_____	_____	Psychological problems

Currently Have	Previously Had	
_____	_____	Rheumatic fever
_____	_____	Seizures
_____	_____	Stroke
_____	_____	Thyroid disease
_____	_____	TB
_____	_____	Ulcers

Currently Have	Previously Had	
_____	_____	Urinary tract infections

Have you ever had any form of cancer? If so, please detail:

_____

_____

Known Allergies (list all and severity):

_____

_____

_____

Current Medications (list all, include dosing):

_____

_____

_____

Current Nutritional Supplements (list all, include dosing):

_____

_____

_____

Do you smoke (check): ____ No; ____ Yes – if yes, how much? _____ How long? _____

Do you consume alcohol (check): ____ No; ____ Yes – how much? _____

Do you use illegal drugs (check): ____ No; ____ Yes – what and how much? _____

PAST SURGICAL HISTORY

Please list any past <u>surgeries</u>, including, but not limited to: Appendectomy; Cholecystectomy (gall bladder removal); Mastectomy (removal of breast material—including for gynocomastia); Tonsillectomy; Prostatectomy; Hernia repair; Other surgeries (please explain):

TYPE OF SURGERY	DATE	OUTCOME (IF APPLICABLE)
TYPE OF SURGERY	DATE	OUTCOME (IF APPLICABLE)
TYPE OF SURGERY	DATE	OUTCOME (IF APPLICABLE)
TYPE OF SURGERY	DATE	OUTCOME (IF APPLICABLE)

Have you ever been hospitalized (other than for the above mentioned surgeries)? If so, please list the reason and give approximate date(s):

REASON	DATE	OUTCOME (IF APPLICABLE)
REASON	DATE	OUTCOME (IF APPLICABLE)
REASON	DATE	OUTCOME (IF APPLICABLE)
REASON	DATE	OUTCOME (IF APPLICABLE)

FAMILY MEDICAL HISTORY

Have your brothers and/or sisters, parents or grandparents, ever had (please tell which family member(s)? Please detail ANY of the below:

- ☐ Heart attack _____
- ☐ Diabetes _____
- ☐ Kidney disease _____
- ☐ Leukemia _____
- ☐ Mental disorders _____
- ☐ Stroke _____
- ☐ Prostate cancer _____
- ☐ Other cancer _____

REVIEW OF SYSTEMS

Do you CURRENTLY have (please check)?:

- ☐ Head aches
- ☐ Vision changes
- ☐ Hearing changes
- ☐ Chronic sinusitis
- ☐ Allergic sinus problems
- ☐ Any tenderness or sores in your mouth or throat
- ☐ Bloody noses
- ☐ Chronic cough
- ☐ Do you spit up blood?
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Dizziness
- ☐ Congestive heart failure
- ☐ Palpitations
- ☐ Any form of arrythmia
- ☐ Heart murmur
- ☐ Recurring constipation
- ☐ Recurring diarrhea
- ☐ Gallbladder disease
- ☐ Throw up blood
- ☐ Blood in your stool or black tarry stool
- ☐ Hernia
- ☐ Loss of appetite
- ☐ Indigestion
- ☐ Nausea

- ☐ Vomiting
- ☐ Jaundice (yellow skin)
- ☐ Do your eyes look yellow?
- ☐ Do you have abdominal pain? If so, please describe and where: _____
- ☐ Pancreatitis
- ☐ Problems urinating (pain, blood, etc.)?
- ☐ Have you ever had a STD (Sexually Transmitted Disease)? Type: _____
- ☐ Tingling in your fingers or toes

REVIEW OF SYSTEMS, Hormone Specific

Do you CURRENTLY have (please check)?:

- ☐ Acne. Describe any acne history (age, severity): _____
- ☐ Do you ever pass out?
- ☐ Do you have cold intolerance?
- ☐ Do you bruise easily?
- ☐ Depression
- ☐ Anxiety
- ☐ Sleep disturbances
- ☐ Generalized muscle aches and pains
- ☐ Joint pain
- ☐ Back pain
- ☐ Fatigue
- ☐ Lethargy

Do you consider yourself to be in good health? ____ No; ____ Yes
Do you sleep well? ____ No; ____ Yes
Average hours of sleep per night: _____

MALE PATIENTS ONLY. Do you CURRENTLY have (please check)?:

- ☐ Decreased sexual potency. If so, is this causing stress in your relationship? ____ No; ____ Yes
- ☐ Nocturnal emissions
- ☐ Sensitive or swollen nipples?
- ☐ Loss of appetite
- ☐ Unexplained weight loss or gain
- ☐ Do you plan on having more children?
- ☐ Has your strength or endurance decreased?
- ☐ Are you enjoying life less?
- ☐ Are you sad or grumpy?
- ☐ Are your erections less strong?
- ☐ Has your work performance decreased?
- ☐ Do you have a hard time recovering from physical activity?

Do you regularly self examine your testicles? ____ No; ____ Yes

Have you ever taken, or are taking any type of hormone (testosterone): ____ No; ____ Yes
If yes, please provide details (age, type, reason): _____
_____
_____

Tell me about your diet (details please)
_____
_____
_____

FEMALE PATIENTS ONLY. Do you CURRENTLY have (please check)?:

- ☐ Decreased sexual potency. If so, is this causing stress in your relationship? ____ No; ____ Yes
- ☐ Osteoporosis
- ☐ PMS or Heavy Menstrual Cycles?
- ☐ Menopausal or Premenopausal?
- ☐ Unexplained weight loss or gain
- ☐ Do you plan on having more children?
- ☐ Has your strength or endurance decreased?
- ☐ Are you enjoying life less?
- ☐ Are you sad or grumpy?
- ☐ Has your work performance decreased?
- ☐ Do you have a hard time recovering from physical activity?

Do you regularly self examine your breasts? ____ No; ____ Yes

Are you currently pregnant or nursing? ____ No; ____ Yes

Date of last mammogram: _____

Do you have any history of breast cancer or ovarian cancer? ____ No; ____ Yes Describe: _____
_____

Have you ever taken, or are taking any type of hormone (progesterone, estrogen, etc.): ____ No; ____ Yes
If yes, please provide details (age, type, reason): _____
_____
_____

Tell me about your diet (details please)

_____
_____

I HAVE COMPLETED THE MEDICAL HISTORY FORM TO THE BEST OF MY KNOWLEDGE. I CERTIFY THAT MY ANSWERS ARE COMPLETE, HONEST AND TRUE.

Signed: _____

Date: _____