COMPREHENSIVE MEDICAL HISTORY

PERSONAL INFORMATION

First Name	Last Name	Date of Birth	Age	
Gender	Social Security Number	Phone	Fax	
☐M ☐F				
Address		Email		
		City	State	Zip
Emergency Contact		Relationship	Phone	
Primary Care Physician		Phone	Fax	

CURRENT HEALTH STATUS

Primary Complaint(s)	Allergies
Current Medications	Current Supplements

HOSPITAL ADMISSIONS & SURGERIES

Reason	Year	Reason	Year

FAMILY HISTORY

Select the illnesses that have affected members of your immediate family only (parents, siblings, grandparents).			
☐Anemia	☐Glaucoma	☐Heart disease	☐Alcoholism
☐Asthma	☐Bleeds easily	☐Hypertension	☐Osteoporosis
☐Epilepsy	☐Hepatitis	☐Alzheimer's disease	☐Diabetes
☐Stroke	☐Thyroid disorder	☐Breast cancer	☐Prostate cancer
☐Lipid disorder	☐Mental illness	☐Ovarian cancer	☐Testicular cancer
☐Hip fracture	☐Arthritis	☐Uterine cancer	☐Other cancer

ILLNESSES & SYMPTOMS

Select the illnesses and/or symptoms you have experienced in the past, or are currently experiencing.			
☐Abdominal pain	☐Stroke	☐Ulcers	☐Decreased height
☐Agitation	☐Cellulite	☐Decreased strength	☐Tingling sensations
☐Frequent urine infections	☐Chest pain	☐Foot pain	☐Persistent nausea or vomiting
☐Asthma	☐Seizures	☐Frequent headaches	☐Thyroid disorder

COMPREHENSIVE MEDICAL HISTORY

ILLNESSES & SYMPTOMS (continued)

Select the illnesses and/or symptoms you have experienced in the past, or are currently experiencing.			
☐ Anxiety	☐ Chronic cough	☐ Shortness of breath	☐ Adult mumps
☐ Arthritis	☐ Chronic fatigue	☐ Sinus trouble	☐ HIV/Aids
☐ Asthma	☐ Ringing in ears	☐ Heart murmur	☐ Irregular pulse
☐ Back pain	☐ Sagging breasts	☐ Heartburn	☐ Jaundice
☐ Blood in urine	☐ Decrease in athleticism	☐ Hemorrhoids	☐ Joint injury or pain
☐ Blood transfusions	☐ Decreased facial hair	☐ Hepatitis	☐ Physical exhaustion
☐ Bloody stools	☐ Decreased hair	☐ Hernia	☐ Kidney stones
☐ Bone fracture	☐ Decreased hearing	☐ Herpes	☐ Low energy
☐ Bronchitis	☐ Dental problems	☐ High blood pressure	☐ Frequent ear infections
☐ Decrease in urine flow	☐ Depression	☐ Hives	☐ Low self esteem
☐ Difficulty sleeping	☐ Diabetes	☐ Hot flashes	☐ Memory loss
☐ Frequent constipation	☐ Difficulty swallowing	☐ Unexplained weight loss	☐ Tuberculosis
☐ Frequent sore throats	☐ Diverticulosis	☐ Wrinkles	☐ Inability to focus
☐ Decreased sense of wellbeing	☐ Dizzy spells	☐ Increased body hair	☐ Muscle weakness
☐ Mental illness	☐ Double or blurred vision	☐ Increased facial hair	☐ Recent loss of appetite
☐ Psoriasis	☐ Dry eyes	☐ Mood swings	☐ Nervousness
☐ Rapid heart beat	☐ Dry skin	☐ Urine leakage	☐ Night sweats
☐ Suicidal thoughts	☐ Frequent diarrhea	☐ Varicose veins	☐ Frequent nighttime urination
☐ Swollen ankles	☐ Progressive hair loss	☐ Recurrent nose bleeds	☐ Numbness
☐ Painful urination	☐ Overactive bladder	☐ Osteoporosis	☐ Prostate cancer
☐ Breast cancer	☐ Ovarian cancer	☐ Uterine cancer	☐ Testicular cancer

NUTRITION

Height	Weight	BMI	Desired Weight

What are the most important reasons you want to lose weight?	In the past, what has stopped you from losing weight?
How often do you eat out?	How often do you eat out?

List any diets you have been on in the past 12 months and the benefits or problems you experienced.

Do you use weight gain/loss supplements? If YES, please explain.

☐ Y ☐ N

List any food intolerances.

COMPREHENSIVE MEDICAL HISTORY

NUTRITION (continued)

Define the weekly number of servings in ounces you have for each of the food/beverage items below.

CARBOHYDRATEES	SERVINGS	CARBOHYDRATEES	SERVINGS	PROTEINS	SERVINGS	BEVERAGES	SERVINGS
Fruit		Cookies		Fish		Water	
Vegetables		Crackers		Poultry		Juice	
Whole breads		Potato chips		Red meat		Coffee	
Refined breads		Brown rice		Eggs		Tea	
Candy		White rice		Nuts		Soda	
Cake		Fast food		Protein snacks		Alcohol	

DIABETICS

Most Recent Hemoglobin A1C %	Date	Insulin Dosing Protocol

Previous Diabetes Medications	What is the reason for discontinuation of any diabetes medications?

EXERCISE

Use the following chart to rate the exercises you list below.

Frequency	The number of times per week you engage in this exercise
Intensity	1 = Light aerobic exercise (normal walking, golfing) 2 = Low-moderate aerobic and sports activities (recreational volleyball, moderate speed walking) 3 = Moderate aerobic activities (normal bike riding, jogging, low impact aerobics) 4 = Moderately high aerobic activities and intermittent sports activities (tennis, stair-stepping, squash) 5 = High intensity activities that result in sustained heavy breathing and perspiration (running, distance cycling)
Duration	How many minutes you exercise per session
Year Began	What year you began doing this form of exercise

TYPE OF EXERCISE	FREQUENCY	INTENSITY	DURATION	YEAR BEGAN

COGNITIVE FUNCTION

Select only the statements which apply to you.

☐ Sometimes I forget what day of the week it is.	☐ My friends and family think I'm more forgetful now.
☐ Sometimes when I'm looking for something I forget what it is.	☐ Sometimes I forget the names of my friends.
☐ It's hard for me to add two-digit numbers mentally.	☐ It's hard for me to concentrate for even an hour.
☐ I frequently forget appointments.	☐ I often misplace my keys.
☐ I rarely feel energetic.	☐ I frequently repeat myself.
☐ Small problems upset me more than they once did.	☐ Sometimes I get lost when driving somewhere I've been.
☐ It takes me longer to learn something than it used to.	☐ I often forget the point I'm trying to make.
☐ I find it difficult to multi-task.	☐ To feel mentally sharp, I depend upon caffeine.

COMPREHENSIVE MEDICAL HISTORY

SLEEP

What time do you wake up?	What time do you go to bed?	Do you feel refreshed waking up?	Do you use sleep aids?
		☐Y ☐N	☐Y ☐N
How long does it take you to fall asleep?		How many times do you wake up at night?	

MEN: ANDROPAUSE ASSESSMENT

Select only the statements which apply to you.	
☐Fatigue, tiredness, loss of energy	☐Anxiety, nervousness
☐Irritability, anger, bad temper	☐Relationship problems with partner
☐Low libido	☐Erectile dysfunction during sex
☐Decreased morning erections	☐Decreased intensity of orgasms
☐Backache, joint pain, stiffness	☐Loss of fitness
☐Memory loss, decreased ability to concentrate	☐Feeling over-stressed

HORMONE REPLACEMENT THERAPY QUESTIONNAIRE

Do you have any experience with hormone replacement therapy? If YES, please explain.
☐Y ☐N
Are there any treatments you are particulary interested in? If YES, please explain.
☐Y ☐N
What are you hoping to gain with hormone replacement therapy?

MISCELLANEOUS

Please include any additional information we should know.

Signature	Name	Date

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