All Patients:

Ethnicity: □White □African American □Native American □Hispanic □Asian □Other:_____

How would rate your current health:
□Excellent □ Good □ Average □ Fair □Poor

Have you had any significant illness or hospitalizations in the last year? □ Yes □ No
If yes, please specify: _____
_____

Please list any surgical procedures you have had with dates:

_____ _____
_____ _____

Please list any history of trauma you have experienced (ie car accidents, head injuries, broken bone):

_____ _____
_____ _____

Are you allergic to any foods? □ Yes □ No
If yes, what food(s) and describe the reaction: _____

Are you allergic to any medication? □ Yes □ No
If yes, what medication and describe the reaction:

_____
_____

Please list all medication are currently taking. Include prescription, vitamins, herbal supplements and over the counter medication with dosage and frequency:

Medication	Condition	Dosage	Times per day

Patient's Name:_____ Date of Birth: _____ Date: _____
Vitals: B/P _____/_____ Pulse _____ Temp _____ Height _____ Weight _____

Social/Lifestyle History

Current Emotional Health _____
Current Relationship/Quality _____
Current Predominant Emotion _____
Occupation _____ Stress Level _____
Have you had any unusual stresses recently? _____
Favorite time of year (body type) _____ Worst _____
Hobbies & Recreational Habits _____
Do you have a regular exercise program? □ Yes □ No if so, please describe: _____
Have you traveled abroad in the past year? □ Yes □ No Where? _____

Do you have any children? □ Yes □ No How many? _____
How many servings of an alcoholic beverage do you consume in an average week? _____
Note: A serving is defined as a 12-ounce beer, 5-oz glass of wine or 1.5-ounces of liquor?

For present and past Tobacco Users:

Do you currently use tobacco? □ Yes □ No If yes, what type? (check all that apply)
□ Cigarettes How many per day? _____
□ Pipe How many per day? _____
□ Snuff How many per day? _____
□ Cigars How many per day? _____
□ Chewing Tobacco How many per day? _____

If you previously used tobacco, what type did you use? (check all that apply)
□ Cigarettes How many per day? _____
□ Pipe How many per day? _____
□ Snuff How many per day? _____
□ Cigars How many per day? _____
□ Chewing Tobacco How many per day? _____

How many years did you use tobacco? _____
When did you quit? _____
How many times have your tried to quit? _____
Do you use a seat belt? □Always □Most of the time □Sometimes □Never
Do you have a working smoke detector? □Yes □No
Do you have a working carbon monoxide detector? □Yes □No

Are you experiencing stress? □Yes □No
How well do you feel you are able to manage stress? □ Excellent □Good □Average □Fair
Who is your support system? _____
_____

From the list, select all the methods you use to relieve tension and/or stress:

□ Read
□ Listen to music/play music
□ Smoke Cigarettes/Pipe
□ Sleep
□ Watch Television
□ Cry
□ Throw things
□ Other:_____
□ Meditate
□ Blow up
□ Eat
□ Exercise or walk
□ Don't think about it
□ Work/Housework
□ Alcoholic Beverages
□ Do nothing
□ Turn to faith/pray
□ Take a drug
□ Go for a drive
□ Call a friend/relative
□ Draw/Paint/Hobby
□ Time with friend/relative

Have you ever been treated for emotional problems? _____
Have you ever considered or attempted suicide? _____
Any other neurological or psychological problems? _____
Any nervous habits? _____

Do you experience any of the following symptoms when under stress? (Select all that apply)

□ Inability to sleep □ Chest Pain □ Nervousness
□ Upset stomach □ Irritability □ Other:_____

On average, how many hours of restful sleep do you get per night? _____
How many hours of sleep do you think you need? _____
During the past month, what percent of the time would you say your wake up feeling fresh and fully rested? _____

Fitness Activity Assessment

Do you enjoy exercising? □Yes □No
Have you ever been a member of a health club? □Yes □No
If yes, for how long? _____
Are you currently a member of a health club? □Yes □No
Have you ever worked with a personal trainer? □Yes □No
If yes, for how long? _____
Did you enjoy it? □Yes □No
Are you still with a personal trainer? □Yes □No
Do you have an exercise partner? □Yes □No
If yes, do they improve your workouts? _____
Are you presently receiving physical therapy? □Yes □No
If yes, please describe:_____
Do you have any exercise equipment at home? □Yes □No
If yes, please list: _____
If exercise is not part of your weekly routine, please explain the reasons:
_____
_____
_____
Did this injury occur as a result of exercising? □Yes □No
Did the injury cause you to modify/stop exercise program? □Yes □No
If yes, for what period of time did you stop exercising? _____

Family History

Condition	Myself	Mother	Father	Maternal Grandparents	Paternal Grandparents
Heart Disease	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Gastrointestinal Disorder	☐	☐	☐	☐	☐
Kidney/Bladder Disease	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐
Stroke (TIA)	☐	☐	☐	☐	☐
Migraines/Headaches	☐	☐	☐	☐	☐
Parkinson's Disease	☐	☐	☐	☐	☐
Tremor	☐	☐	☐	☐	☐
Autoimmune Disorders	☐	☐	☐	☐	☐
Seizure Disorder	☐	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

Please provide an explanation of any items for which you checked "myself":

_____

_____

_____

_____

_____

PLEASE CHECK IF YOU HAVE EXPERIENCED (IN THE LAST THREE(3) MONTHS):

GENERAL

□ Fevers
□ Chills
□ Fatigue
□ Tremors
□ Seizures
□ Night sweats
□ Change in Appetite
□ Peculiar tastes or smells
□ Sudden energy drops?

What time of day? _____

□ Poor sleep/Insomnia
□ Dream Disturbed Sleep
□ Depression
□ Mania
□ Emotional changes
□ Day sweating
□ Poor Balance
□ Weight Loss
□ Weight Gain
□ Poor Appetite
□ Strong thirst for hot or cold drinks?
□ Headaches
□ Localized Weakness
□ Bleeding or Bruising
□ Joint pain

CARDIOVASCULAR

□ High blood pressure
□ Irregular heartbeat
□ Low blood pressure
□ Chest pain
□ Dizziness
□ Fainting
□ Cold sweats
□ Swelling of Feet
□ Swelling of hands
□ Difficulty in breathing
□ Cold Hands/Feet
□ Phlebitis
□ Blood Clots
□ Palpitations

RESPIRATORY

□ Cough
□ Asthma
□ easily winded w/exertion when laying down
□ Pain w/deep breaths
□ Bronchitis
□ Difficulty in breathing
□ Shortness of Breath
□ Production of phlegm
what color? _____

GASTROINTESTINAL

□ Nausea
□ Vomiting
□ Indigestion
□ Ulcers
□ Hernia
□ Abdominal Pain/ Cramps
□ Parasites
□ Belching
□ Bad Breath
□ Hemorrhoids
□ Digestive Disorders
□ Constipation
□ Diarrhea
□ Blood in stools

GENITO-URINARY

□ Pain on urination
□ Urgent urination
□ Frequent urination
□ Decrease in urine
□ Blood in urine
□ impotency/infertility
□ Kidney sores
□ Waking up to urinate
How often? _____

MUSCULOSKELETAL

□ Muscular Weakness
□ Muscle
□ Injuries or Falls
□ General Aches
□ Arthritis
□ Spasm
□ Muscular Atrophy
□ Joint Instability
□ Recent Sprains

Males Only:

Do you use Viagra, Cialis, Levitra or any other erectile enhancement drugs? □Yes □No

If yes, which one(s) and how often? _____

Have these drugs helped you? □Yes □No

Have you ever used any other medications for sexual function? □Yes □No

If yes, please list and describe results: _____

Have you ever used testosterone, HCG, DHEA, or HGH? □Yes □No

If yes, which one(s) and when? _____

Under the categories listed below, check the "yes" column only if you are experiencing the listed symptom to a substantial or unusual degree:

Difficulty Attaining/Maintaining Erection	□Yes	□No
Sex Drive: Underactive	□Yes	□No
Sex Drive: Overactive	□Yes	□No
History of infertility/low sperm count	□Yes	□No
Lack of Early Morning Erections	□Yes	□No
Lump or mass in scrotum	□Yes	□No
Past or present Sexually Transmitted Disease	□Yes	□No

If you answered yes to any of the above, please explain: _____

_____

_____

Please advise if the tests listed below have been completed. If yes, provide the most recent date and results.

Exam:			Test Date & Results:
Prostate Exam	□Yes	□No	_____
PSA	□Yes	□No	_____
Colonoscopy	□Yes	□No	_____
Rectal Exam	□Yes	□No	_____
EKG	□Yes	□No	_____
Stress Test	□Yes	□No	_____
Nuclear Stress Test	□Yes	□No	_____
Chest X-ray	□Yes	□No	_____
Eye Exam/Eye Pressures	□Yes	□No	_____
EMG/Nerve Conduction	□Yes	□No	_____
Other:_____	□Yes	□No	_____

Females only:

Are you still menstruating? □Yes □No If yes, date of last menstrual period: _____
How many days does cycle/bleeding occur? _____
Would you describe cycle as □Regular □Irregular
Would you describe flow as □Light □Moderate □Heavy
Form of birth control: □None □Hormonal Contraceptive □IUD □Diaphragm □Condom
□Tubal Ligation □Hysterectomy □Vasectomy (partner) □Other:_____
Have you had a hysterectomy? □Yes □No
If yes, please give date and reason: _____
Have your ever taken estrogen, progesterone, testosterone, DHEA or HGH? □Yes □No
If yes, which one(s) and when? _____

Under the categories listed below, check the "yes" column only if you are experiencing the listed symptom to a substantial or unusual degree:

Menstrual Pain	□Yes	□No	
Hot Flashes/Night Sweats	□Yes	□No	
Sex Drive: Underactive	□Yes	□No	
Pre-Menstrual Syndrome(PMS)	□Yes	□No	
Vaginal Dryness	□Yes	□No	
Vaginal Itching	□Yes	□No	
Pain with intercourse	□Yes	□No	
Urinary Incontinence/Leaking	□Yes	□No	
Fluid Retention/Bloating	□Yes	□No	
Breast tenderness	□Yes	□No	
History of infertility	□Yes	□No	
History of miscarriages	□Yes	□No	If yes, how many: _____
History of ovarian cysts	□Yes	□No	
History of Uterine Cysts/Fibroids	□Yes	□No	
History of endometriosis	□Yes	□No	
Lump or mass in breast	□Yes	□No	
Past or present Sexually Transmitted Disease	□Yes	□No	

If you answered yes to any of the above, please explain: _____
_____
_____

Please advise if the tests listed below have been completed. If yes, provide the most recent date and results.

Exam:			Test Date & Results:
Pap Smear/Pelvic Exam	□Yes	□No	_____
Pelvic Ultrasound	□Yes	□No	_____
Breast Exam	□Yes	□No	_____
Mammogram	□Yes	□No	_____
Colonoscopy	□Yes	□No	_____
Rectal Exam	□Yes	□No	_____
EKG	□Yes	□No	_____
Stress Test	□Yes	□No	_____
Nuclear Stress Test	□Yes	□No	_____
Chest X-ray	□Yes	□No	_____
Eye Exam/Eye Pressures	□Yes	□No	_____

EMG/Nerve Conduction □Yes □No ____