

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

Currently	Previously	
Have	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 surgeries, 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)
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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 arrhythmia
- 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: _____