

Medical History Form

Date of Visit: _____

Section 1. Personal Information

Referred by: _____

Name: _____ Email: _____ SSN# _____

ADDRESS

Street _____

City _____

State/Province _____

Zip _____

Country _____

PHONE NUMBERS

Home _____

Work _____

Mobile _____

Fax _____

Occupation _____

Section 2. Confidential Medical History

Medical History Information

Date of Birth _____ Gender _____ Age _____

Weight _____ Height _____

Primary Physician Information

Physician's Name _____ Phone _____

Date of your last physical examination with your physician _____

Family History: Does an immediate family member currently have or ever had any of the following:

Condition:	YES	NO
Cardiovascular disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes, thyroid or other	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine disorder		
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Lipid disorder	<input type="checkbox"/>	<input type="checkbox"/>
Other forms of cancer	<input type="checkbox"/>	<input type="checkbox"/>
Prostate cancer	<input type="checkbox"/>	<input type="checkbox"/>
Other illnesses	<input type="checkbox"/>	<input type="checkbox"/>

Please list reasons for your visit:

Lifestyle Information

	YES	NO	DETAILS
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much do you smoke per day?
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much per week?
Are you taking over the counter supplements?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, list name and quantity per day/week.
Do you exercise regularly?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please describe

Diagnosed History of Disease: Do you currently have or ever had any of the following?

If yes, please explain in the box below:

	YES	NO
Any known deficiency including minerals and electrolytes	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorders	<input type="checkbox"/>	<input type="checkbox"/>
Cancer		
Carpal Tunnel syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Orthopedic or muscle disorder including fracture or joint disorders	<input type="checkbox"/>	<input type="checkbox"/>
Allergies to medications	<input type="checkbox"/>	<input type="checkbox"/>
Edema/excess fluid retention	<input type="checkbox"/>	<input type="checkbox"/>
Emotional disorders/depression	<input type="checkbox"/>	<input type="checkbox"/>
Genital – Urinary disorder	<input type="checkbox"/>	<input type="checkbox"/>
Hyperlipidemia	<input type="checkbox"/>	<input type="checkbox"/>
Neurological disorders, thyroid, diabetes, or other	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine disorder including insulin resistance, or diabetes		
Bursitis	<input type="checkbox"/>	<input type="checkbox"/>
Sports Injury (s)	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
Use of medication	<input type="checkbox"/>	<input type="checkbox"/>
Immune disorders	<input type="checkbox"/>	<input type="checkbox"/>
Chemical dependency	<input type="checkbox"/>	<input type="checkbox"/>
Lung disorder	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease (including Atherosclerosis, Angina, Heart Failure, Heart Attack)	<input type="checkbox"/>	<input type="checkbox"/>
Upper respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Poor wound healing	<input type="checkbox"/>	<input type="checkbox"/>
Renal disease	<input type="checkbox"/>	<input type="checkbox"/>
Other illnesses	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>

Questions for Treatment: Do you currently have or ever had any of the following symptoms?

If yes, please check and explain below:

	YES	NO
Decreased desire and ability to exercise	<input type="checkbox"/>	<input type="checkbox"/>
Cold or heat intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Decreased energy or endurance	<input type="checkbox"/>	<input type="checkbox"/>
Decreased sense of well-being	<input type="checkbox"/>	<input type="checkbox"/>
Decreasing memory	<input type="checkbox"/>	<input type="checkbox"/>
Decreasing muscle strength	<input type="checkbox"/>	<input type="checkbox"/>
Loss of concentration, sociability, activity	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty sleeping	<input type="checkbox"/>	<input type="checkbox"/>
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>
Increased lack of drive	<input type="checkbox"/>	<input type="checkbox"/>
Increasing fat deposits about abdomen and/or thighs	<input type="checkbox"/>	<input type="checkbox"/>
Increasing mood swings	<input type="checkbox"/>	<input type="checkbox"/>
Increasing sagging muscles or breasts	<input type="checkbox"/>	<input type="checkbox"/>
Increasing wrinkles	<input type="checkbox"/>	<input type="checkbox"/>
Increasingly stressed	<input type="checkbox"/>	<input type="checkbox"/>
Decreasing size of testicles	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
Loss of interest in sex	<input type="checkbox"/>	<input type="checkbox"/>
Muscle loss	<input type="checkbox"/>	<input type="checkbox"/>
Progressive osteoporosis, decreasing bone mass, stooped posture	<input type="checkbox"/>	<input type="checkbox"/>
Sagging, loose or thin skin	<input type="checkbox"/>	<input type="checkbox"/>
Thinning or loss of hair	<input type="checkbox"/>	<input type="checkbox"/>
Urogenital atrophy	<input type="checkbox"/>	<input type="checkbox"/>
Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Weight loss-unexplained	<input type="checkbox"/>	<input type="checkbox"/>
Currently Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Pain in any joint or muscles	<input type="checkbox"/>	<input type="checkbox"/>

Please answer every item. If you are not sure whether to answer YES or NO, pick whichever answer you think is most true in general.

	YES	NO
I have to struggle to finish jobs	<input type="checkbox"/>	<input type="checkbox"/>
I feel a strong need to sleep during the day	<input type="checkbox"/>	<input type="checkbox"/>
I often feel lonely even when I am with other people	<input type="checkbox"/>	<input type="checkbox"/>
I have to read things several times before they sink in	<input type="checkbox"/>	<input type="checkbox"/>
It is difficult for me to make friends	<input type="checkbox"/>	<input type="checkbox"/>
It takes a lot of effort for me to do simple tasks	<input type="checkbox"/>	<input type="checkbox"/>
I have difficulty controlling my emotions	<input type="checkbox"/>	<input type="checkbox"/>
I often lose track of what I want to say	<input type="checkbox"/>	<input type="checkbox"/>
I lack confidence	<input type="checkbox"/>	<input type="checkbox"/>
I have to push myself to do things	<input type="checkbox"/>	<input type="checkbox"/>
I often feel very tense	<input type="checkbox"/>	<input type="checkbox"/>
I feel as if I let people down	<input type="checkbox"/>	<input type="checkbox"/>
I find it hard to mix with people	<input type="checkbox"/>	<input type="checkbox"/>
I feel worn out even when I've not done anything	<input type="checkbox"/>	<input type="checkbox"/>
There are times when I feel very low	<input type="checkbox"/>	<input type="checkbox"/>
I avoid responsibilities if possible	<input type="checkbox"/>	<input type="checkbox"/>
I avoid mixing with people I don't know well	<input type="checkbox"/>	<input type="checkbox"/>
I feel as if I am a burden to people	<input type="checkbox"/>	<input type="checkbox"/>
I often forget what people have said to me	<input type="checkbox"/>	<input type="checkbox"/>
I find it difficult to plan ahead	<input type="checkbox"/>	<input type="checkbox"/>
I am easily irritated by other people	<input type="checkbox"/>	<input type="checkbox"/>
I often feel too tired to do the things I ought to do	<input type="checkbox"/>	<input type="checkbox"/>

YES NO

I have to force myself to do all the things that need doing

I often have to force myself to stay awake

My memory lets me down

Please use this space to explain any YES answers for allergies to medications, surgeries, hospitalizations, disease, or any additional information:

List all the medications you are taking. Please be specific (name, dosage, etc.) or specify "none."

YES NO

Prior history of steroids or hormones?

If yes, please describe:

Male: _____

Last used: _____

Female (including birth control):

Type/Dose/Frequency: _____

Last used: _____

YES NO

Prior Medical Records/Labs

Any side effects?

Used estrogen-blocker?

Comments: _____

Existing Patients: Please write the symptoms you have improved and hope to continue to improve through BHRT.

New Patients: Please write the symptoms you would like to see improve through BHRT.

Please use this space to explain “other” and write any additional information:

Please provide the most recent date and results for the tests listed below.

Test Dates	Results
Prostate Exam	
PSA	
Colonoscopy	
Sigmoidoscopy	
Rectal Exam	
Resting EKG	
Stress EKG	
Stress Echo	
Nuclear Stress	
Chest X-ray	
Eye Exam/eye pressures	

Nutrition Questionnaire

Name _____ Date _____

Age _____ Height _____ Weight _____

What is your main reason for this consultation? (Please circle): Weight Loss, Weight Gain, Increase Energy, Better Health, Increase Muscle Mass, Decrease Body Fat, Disease Prevention, High Cholesterol, Hypertension, Post Pregnancy, and Diabetic Control.

Other _____

Please list any medical diagnoses (i.e. Diabetes, High Blood Pressure, Osteoporosis, IBS, etc.)

Please list any surgeries / or hospitalizations.

Please list any food allergies _____

Is there any history of medical problems? (I.e. Immediate members of family have heart disease, high cholesterol, diabetes, cancer, etc.) _____

Please list any psychological diagnoses (i.e. anorexia, bulimia, depression, etc.)

FEMALES ONLY:

Are your menstrual cycles regular? Yes NO

How long does your cycle last? _____

Has your menstrual cycles ever been irregular? _____

Please list any medications you are taking on a regular basis. (Including birth control pills, cholesterol meds, etc.)

Are you taking any food and / or vitamin supplements. Please list (including herbs, sports drinks, and whey or casein protein powder): _____

Marital status _____ Children and ages _____

Who does the cooking? _____ Who does the food shopping? _____

Do you have a kitchen at work? (I.e. refrigerator, microwave available) _____

Have you ever worked with a dietitian? Yes No

What was your highest weight? _____ age _____

What was your lowest weight? _____ age _____

How often do you weight yourself? _____

What weight do you feel most comfortable at? _____

Last time you weighed this, and for how long? _____

Are any members of your family overweight? YES NO

If you answered yes, has their eating influenced your eating behavior in any way? YES NO

Are you currently exercising? Yes No

If you answered yes please list amount and types of exercises? (Cardio, weight training, etc) Be as specific as possible. Please list number of days/week and time spent doing each activity. Also, try to give intensity levels or speeds of machines so that we can determine how many calories you burn on a weekly basis from exercise.

What do you consider to be your problem areas? (Please Circle):

Craving salt - Craving sweets - Bingeing late at night - Bingeing late in the afternoon - Stress eating - Boredom eating

Other, Please specify _____

Do you often skip meals? YES NO

Do you usually eat when you are hungry? YES NO

Do you often eat when you are not hungry? YES NO

Do you often eat on a scheduled time? YES NO

Specify: _____

Please list the foods you like the most:

Please list the foods you dislike the most:

Are you a vegetarian? Yes No

If so, Please specify which foods you have eliminated from your diet:

How much water do you drink daily? _____

How much regular soda do you drink daily? _____

How much diet soda do you drink daily? _____

How many alcoholic beverages do you drink on a daily or weekly basis? _____

(Please specify type of alcohol and size of drink, where are they consumed at home or at restaurants)

Please circle and list the foods that you like.

CARBOHYDRATES

GRAINS: whole wheat bread, white bread, rye bread, bagels, oatmeal, brown rice, white rice, whole wheat pasta, regular pasta, pretzels, popcorn (air popped), All Bran Cereal, Shredded wheat, Cheerios, pancakes, waffles, Raisin Bran, Corn Flakes, Frosted Flakes. Please specify other grains that you do and don't like: _____

FRUITS: cantaloupe, honeydew, strawberries, bananas, apples, oranges, grapefruit, applesauce (no sugar added), peaches, plums, pineapple, pears, nectarines, watermelon, raisins, blueberries, kiwi, mango, grapes, orange juice. Please specify other fruits that you do and don't like: _____

VEGETABLES: corn, peas, potatoes, sweet potatoes, spinach, kale, carrots, romaine lettuce, red leaf lettuce, iceberg lettuce, red peppers, green peppers, yellow peppers, broccoli, cauliflower, brussel sprouts, cabbage, asparagus, squash, artichokes, baby carrots, mushrooms, celery, cucumber, beets, tomatoes, olives, snow peas, green beans, onions, edename, escarole. Please specify other vegetables that you do and don't like: _____

PROTEINS

Dairy: 1% milk, 2% milk, skim, half and half, light cream, lactose reduced milk, soy milk, rice milk, plain low fat yogurt, plain nonfat yogurt, yogurt fruit flavored(light, nonfat), low fat cheese, nonfat cheese, regular cheese, cheese sticks, soy cheese, regular cottage cheese, low fat cottage cheese, fat free cottage cheese, cottage cheese with fruit, parmesan cheese, Romano cheese, regular sour cream, low fat sour cream, non fat sour cream, whey powder, casein powder, eggs, egg whites, egg beaters. Please specify other proteins you do and don't like: _____

MEAT : Skinless chicken breast, skinless turkey breast, ground chuck or round meat, pork loin, Canadian bacon, salmon, tuna, shrimp, clams, scallops, Chilean Sea Bass, Filet of Sole, trout, red snapper, grouper, crab, sushi rolls, tofu, veggie burgers, turkey dogs, soy dogs, peanuts, cashews, almonds, Beans: pinto, red, black, refried, chick peas, hummus. Please specify other meat proteins that you do and don't like: _____

OTHERS: NutraSweet, Equal, sweet n low, Stevia, low-fat baked chips, non-fat frozen yogurt/ice cream, low fat frozen yogurt/ice cream, hot chocolate with water or milk, peppermint patties, sugar free fudge popsicles/juice pops, 100% fruit juice pops, soda, diet soda, fruit juice, vegetable juice, crystal light, decaf tea, decaf coffee, regular coffee, low sugar jelly, regular mayonnaise, reduced fat mayonnaise, fat free mayonnaise, butter buds, butter spray, regular butter, light butter, I can't believe it's not butter, tub spreads, margarine, ketchup, mustard, cooking spray, canola oil, olive oil, reduced calorie dressing, regular salad dressing.

Any Other: _____

Please include any other information that might be helpful for me to know: _____

What would you like to learn about in our sessions? _____

Please list 2 days of your daily intake and times of eating? Be as specific as you can. Thank You

	DAY 1	DAY 2
Morning _____		

Noon _____		

Evening _____		

Night _____		

Personal Fitness Health Questionnaire

Name: _____ Date: _____

Phone: _____ Age: _____

Sex: Male Female

Medical History

Do you have any of the following?

	Yes	No
CHEST DISCOMFORT	<input type="checkbox"/>	<input type="checkbox"/>
HEART ATTACK	<input type="checkbox"/>	<input type="checkbox"/>
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>
ABNORMAL EKG	<input type="checkbox"/>	<input type="checkbox"/>
ABNORMAL HEART BEATS	<input type="checkbox"/>	<input type="checkbox"/>
HIGH CHOLESTEROL	<input type="checkbox"/>	<input type="checkbox"/>
PULMONARY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
HYPOGLYCEMIA	<input type="checkbox"/>	<input type="checkbox"/>
MUSCULOSKELETAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
OTHER CONDITIONS/ ILLNESSES	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please explain:

Are you currently on any medications? YES NO

If yes, please explain:

g) Strenuous housework _____

h) Gardening, including strenuous digging _____

2. If you do aerobic exercise, how long is your average workout? _____

3. What is the intensity of your aerobic exercise? Please indicate

____ Very Light Stretching

____ Light includes some movement (Example a leisurely walk)

____ Moderate Continuous movement involving fluctuation in intensity from moderate to heavy with significant increases in heart rate

____ Very Heavy Continuous movement causing heavy breathing, sweating, marked increases in heart rate (swimming laps, interval training, running, cycling, stationary bike, spin cycling)

4. Do you on a regular basis: Walk Y/N Jog Y/N Run Y/N

a) If yes, how many times per week? _____ b) What is the average number of miles per workout? _____

5. During the past year, have you experienced any injuries? YES NO

a) If yes, describe your injury? _____

b) Did this injury occur as a result of exercising? YES NO

c) Did this injury cause you to modify or stop your exercise regimen? YES NO

d) If yes, for what period of time did you stop exercising? _____

Do you enjoy exercising? YES NO

Have you ever been a member of a health club? YES NO

Are you currently a member of a health club? YES NO

Have you ever worked with a personal trainer? YES NO

If yes how long? _____

Did you enjoy it? YES NO

Are you still working with a personal trainer? YES NO

Do you have any exercise equipment at home (bike, treadmill, free weights, etc.)? YES NO

If yes, please list: _____

Are you presently receiving physical therapy? YES NO

If yes, please describe: _____

If exercise is not part of your weekly routine, please explain the reason.
