NEW PATIENT

Welcome to our practice. As a new patient, please answer the questions below to the best of your ability. The Initial Consult Fee is $ 375.00

HEALTH SURVEY

Date _____ **Patient No**_____

Patient Name _____ **Birth Date** _____

Home Phone _____ **Work or Cell Phone** _____ **Email** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

Describe your main complaint(s) _____

_____

If your complaint is due to pain, complete the following:

Location _____ **Severity on a scale of 1** _____**10**

Quality _____ **Duration** _____

Time _____ **What makes it better or worse?** _____

Do you have any other health concerns? _____

MEDICAL HISTORY: List any other doctors you've seen for this condition _____

Who is your current family physician? _____ **Specialist?** _____

Date of your last physical exam _____ **When did you have your last blood tests?** _____

List any diagnoses or treatments _____

List any surgeries or major illness with date of occurrence _____

Have you had any infectious diseases? _____

Have you been hospitalized for this or any condition? _____

Do you have any allergies? _____ **Have you ever reacted to medications?** _____

MEDICATIONS: List all prescription or over-the-counter drugs you are taking _____

_____

FAMILY HISTORY: Has anyone in your immediate family had any of the following conditions?

- ☐ Heart or coronary arterial disease (congestive heart failure, angina, etc.) _____
- ☐ Atherosclerosis (hardening of the arteries) _____
- ☐ High cholesterol or other form of abnormal lipids _____
- ☐ Heart attack or stroke _____
- ☐ Diabetes or any form of metabolic disease or obesity _____
- ☐ Cancer and list type(s) _____
- ☐ Osteoporosis or any form of bone disease _____
- ☐ Thyroid disease _____
- ☐ List any other diseases in your family _____

ADDITIONAL INFORMATION: Describe any other information you feel is important for your doctor to know

NUTRITION REVIEW

NUTRIONAL SUPPLEMENTS: List all vitamin, mineral, and other nutritional or herbal supplements

_____

_____

LIFE STYLE INFORMATION: Answer the following questions with YES or NO and explain if necessary

- ☐ **Do you exercise? How often? _____ What type? _____**
- ☐ **Do you use alcohol? How often? _____ What kind? _____**
- ☐ **Do you smoke? How much? _____ For how long? _____ When did you quite? _____**
- ☐ **Do you drink coffee? _____**
- ☐ **Do you drink caffeinated sodas? _____**
- ☐ **Do you follow a specific diet? _____**
- ☐ **Are you concerned about your weight? Are you following a specific diet? _____**
- ☐ **Do you overeat? How is your appetite? _____ Do you have any reactions to foods? _____**
- ☐ **Do you crave sweets? Do you have any other food cravings? _____Or aversions? _____**
- ☐ **Are you concerned about aging? Do you have a specific concern? _____**
- ☐ **Are you concerned about your appearance? Have you used any aesthetic therapies? _____**
- ☐ **Are you stressed or anxious? _____**
- ☐ **Do you or have you experienced depression? Is there any form of depression or dementia in your family? _____**
- ☐ **Do you suffer from insomnia or any other form of sleep abnormality? _____**
- ☐ **Are you concerned about memory loss? _____**
- ☐ **Do you practice any form of stress reduction such as meditation, tai chi or yoga? _____**
- ☐ **Is your relationship fulfilling? _____ How is your children's health? _____**
- ☐ **Do you experience fatigue? _____**

DIETARY INFORMATION: Describe your daily diet

_____

_____

BIOMARKER QUESTIONNAIRE

Age _____ Sex_____ Height _____ Weight _____ BMI _____

Have you experienced any of the following?

- ☐ Decreasing muscle mass
- ☐ Reduced strength
- ☐ Decreased joint mobility
- ☐ Increased stiffness
- ☐ Reduced capacity for work and exercise
- ☐ Decreased endurance
- ☐ Significant weight loss
- ☐ Increased body fat
- ☐ Increased waist to hip ratio (more fat deposits on the abdomen and waist)
- ☐ Reduced sexual drive and/or performance
- ☐ Muscle mass loss or flabbiness
- ☐ Changes in body temperature
- ☐ Sensitivity to cold or heat
- ☐ Hot flashes
- ☐ Dryer or thinning skin and hair
- ☐ Brown or red spots
- ☐ Spider veins on the skin
- ☐ Slow wound healing
- ☐ Frequent colds or flu
- ☐ Presence of viral infections: Herpes Zoster (shingles), Epstein Barr, HIV, HHV-6, Hepatitis
- ☐ Chronic pain or inflammation
- ☐ Poor sleep
- ☐ Waking up tired
- ☐ Fatigue
- ☐ Longer recovery time needed after exertion
- ☐ Forgetfulness
- ☐ Increasing difficulty concentrating
- ☐ Mood changes
- ☐ Unexplained depression
- ☐ Anxiety
- ☐ Increased anger or irritability
- ☐ Sensitivity to certain foods
- ☐ Craving for sugar
- ☐ Alcohol intolerance

Have you had any of the following tests?

- ☐ Complete Blood Count
- ☐ Chemistry Panel
- ☐ PSA (Prostate Specific Antigen) and prostate exam for men over 40
- ☐ Breast Exam and Mammography for women
- ☐ Pap Smear (for women)
- ☐ Colonoscopy
- ☐ Basal Temperature
- ☐ 3-5 hour Glucose Tolerance Test
- ☐ Fasting insulin
- ☐ Blood Lipids: total Cholesterol, triglycerides, HDL, and LDL
- ☐ Thyroid Studies (TSH, T4)
- ☐ Free T3
- ☐ Homocysteine
- ☐ Blood Pressure
- ☐ Bone Density
- ☐ Treadmill Test
- ☐ Estrogen levels
- ☐ Testosterone
- ☐ Free testosterone
- ☐ IgF-1 (a marker for human growth hormone)
- ☐ DHEA-S
- ☐ Cortisol
- ☐ SHBG (sex hormone binding globulin)

FATIGUE QUESTIONNAIRE

Answer the questions below by checking each applicable box if you have ever experience any of the following:

- ☐ Exhausted feelings that are not related to stress or amount of work or exercise.
- ☐ Morning tiredness, even after a full night's sleep.
- ☐ Depression that does not respond to antidepressants, diet, or exercise.
- ☐ Unexplained anxiety and panic attacks.
- ☐ Been told that I move as if in slow motion, and take too long to responds to questions.
- ☐ A frequently low or hoarse voice (for a woman).
- ☐ Mental sluggishness and have difficulty focusing.
- ☐ Low sex drive and do not experience significant sexual arousal.
- ☐ High cholesterol that has been unresponsive to diet or medications.
- ☐ A tendency to feel cold even in warm weather.
- ☐ Chronic aches and pains not due to accidents or exercise.
- ☐ Carpal tunnel syndrome
- ☐ Problems with allergies.
- ☐ Difficulty losing weight and keeping it off.
- ☐ Very dry skin.
- ☐ I have acne or eczema.
- ☐ Diabetes
- ☐ Rheumatoid arthritis or other autoimmune condition.
- ☐ Problem with my periods, including abnormal menstrual bleeding.
- ☐ Anemia
- ☐ Infertility or a history of frequent miscarriages.
- ☐ Significant menopausal symptoms.
- ☐ A tendency to have chronic constipation even with a high fiber diet.
- ☐ Lots of hair falling out or brittle hair.
- ☐ Vitiligo or other unusual changes in skin color.
- ☐ Trembling of my hands or stumbling for no reason.
- ☐ Have a family history of thyroid disorder
- ☐ Have previously been diagnosed with a thyroid disorder

In case of emergency, notify _____ Phone No. _____Relationship _____

I understand that all fees for consultations, examinations, treatments, and supplies are to be paid for as they are received. My signature is consent for consultation and treatment.

PATIENT'S SIGNATURE: _____ Date _____