

Confidential Medical History Form

Please complete and fax to: (310) 455-5318

Personal Information

Date: _____

Referred By _____

Last Name _____ First name _____

Date of Birth _____ Age _____ Social Security # _____

Address _____

Street

City

State

Postal Code

Country

Home Phone Number _____ Office Phone Number _____

Facsimile Number _____ Beeper Number _____

Cellular Number _____ Alternate Number _____

Occupation _____ Marital Status _____

Spouse Information

Name _____ Date of Birth _____ Age _____

Address _____

Home Phone Number _____ Office Phone Number _____

Cellular Number _____ Alternate Number _____

Parent/ Guardian Information

Name _____

Address _____

Home Phone Number _____ Office Phone Number _____

Cellular Number _____ Alternate Number _____

Emergency Contact Information

Name _____ Relationship _____

Cellular Number _____ Alternate Number _____

Home Phone Number _____ Office Phone Number _____

Your reason for selecting treatment

Confidential Medical History Form Continued

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Name _____
Last First Middle

Please check the appropriate boxes:

Cancer:

Have you ever been diagnosed with any form of cancer? _____

Type? _____

When? _____

Status? _____

Lifestyle:

- premature aging
- Chronic Illness
- Excessive physical and mental exertion
 - Conflicts
 - Inappropriate or inadequate physical activity
 - Convalescence
- Family Stress
 - Large Family
 - increased financial responsibilities
 - Marriage Conflicts
 - Conflicts with children or with parents
 - Loss of loved ones
- Stress at work
 - Poor Motivation
 - Work too routine
 - Interpersonal Rivalry
 - Frustration
- Increased Stress during important changes or phases of life
 - Loss of Job
 - Financial Loss
 - Retirement
 - Menopause
 - Social Isolation
- Stresses of everyday life
 - Large city pressure
 - Social and cultural pressures
- Nutritional Stress
 - Poor dietary habits
 - Intolerance to food additives or preservatives
 - Increased consumption of high caloric-low value foods
- Harmful habits
 - Excessive smoking
 - Excessive alcohol consumption
 - Increased intake of pain medications
 - Gastrointestinal disorders such as constipation due to a poor diet

Cardiovascular Problems:

- myocardial infraction when? _____
- angina pectoris
- tachycardia
- by-pass Surgery when? _____
- hypertension (High blood pressure)
- hypotension (Low blood pressure)

Circulatory:

- Poor arterial circulation
- poor venous circulation
- leg cramps
- tired legs
- swollen ankles
- varicose veins
- tingling sensation in arms and leg
- falling asleep of the hands and legs
- leg ulcers

Gastrointestinal Problems:

- problems with digestion
- acid indigestion
- bloating
- stomach or duodenal ulcer when? _____
- loss of appetite
- rapid weight gain
- rapid weight loss
- overweight problem
- pancreas problem
 - pancreatitis
 - pancreatic insufficiency
- hepatitis
- gall bladder problems
- gall stones
- icterus (jaundice)
- recurring diarrhea

Pulmonary System:

- tubemulosis
- asthma
- chronic bronchitis
- chronic cough
- emphysema

Confidential Medical History Form Continued

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Name _____
Last First Middle

Upper Respiratory Test

- chronic sinusitis
- allergic sinus problem
- chronic allergic rhinitis
- sinus headaches
- chronic nose bleeds
- chronic colds

Neurological System:

- Nervous disturbances (please name)

- depressions
- loss of memory
- decreased concentration
- decreased sexual potency
- headaches
- sleep disturbances
- dizziness
- chronic migraine
- reduced vitality
- psychiatric disturbances

Endocrinological System:

- diabetes mellitus
- thyroid dysfunction overactive
 underactive
- adrenal gland dysfunction
- female menopause (hot flashes, etc.)
- male menopause (andropause-decreased potency)
- other, please list _____

Rheumatic Screen:

- soft tissue rheumatism
- articular rheumatism
- joint pain
- back pain
- rheumatoid arthritis
- other, please list _____

Allergy History:

- Have you ever had an allergic reaction to any of the following:
- food, esp. eggs β _____
- vaccinations β _____
- medications β _____
- hay fever?
- allergic asthma?

General Information:

- Previous medications

- Medications now on

- Anticoagulated ?
Since when? _____
why? _____
- When was your last vaccination?

- When were you last ill ?

- Diagnosis? _____

- Do you smoke?
 cigarettes cigars pipes
 How many?
- Alcohol Consumption?
 wine beer hard liquor
- How much? _____

DHEA or other nutritional supplements you take and dosage schedule

- _____
- _____
- _____
- _____

Operations

What? _____ When? _____

Patient Signature

Date

Confidential Medical History Form Continued

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Today's Date _____

Name _____
Last First Middle

Age _____ Weight _____ Height _____ Sex _____

Date of your last physical Examination _____

Physician _____ Physician Telephone _____

Results of your last physical examination _____

Patient History:

Do you have or have you had any of the following? If the answer is yes, please circle and explain.

Hypoglycemia	Cancer	Leukemia	Anxiety
Diabetes	High Blood Pressure	Arthritis	Lung Problem
Thyroid Problem	Kidney Problem	Prostate Problem	Fatigue
Hormone Problem	Heart Problem	Mental Disorder	Stroke

Are you a diabetic? (circle) Yes No If yes, are you on insulin? (circle) Yes No

List other significant illnesses or diseases you have had. _____

Are you taking prescription medication (circle) Yes No

If yes, please explain _____

Are you allergic to any medications? (circle) Yes No

If yes, please explain _____

Confidential Medical History Form Continued

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Name _____
Last First Middle

List surgical procedures you have had and dates:

Date	Procedure
_____	_____
_____	_____
_____	_____

Previous occasions when you were hospitalized (other than those identified above).

Date	Procedure
_____	_____
_____	_____
_____	_____

Have you been on growth hormone therapy? (circle) Yes No

If yes, how long? _____ Number of IU's of HGH injected per week? _____

Results achieved to date with any growth hormone replacement therapy

Family History

If there is a member of your family with a history of the following conditions, please circle and explain.

- | | | | |
|-----------------|---------------------|------------------|--------------|
| Hypoglycemia | Cancer | Leukemia | Anxiety |
| Diabetes | High Blood Pressure | Arthritis | Lung Problem |
| Thyroid Problem | Kidney Problem | Prostate Problem | Fatigue |
| Hormone Problem | Heart Problem | Mental Disorder | Stroke |

List any significant illnesses a family member has had (other than those identified above)

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Name _____
Last First Middle

Overall Health

Are you in good health? (circle) Yes No

If no, please explain _____

Do you have a good appetite? (circle) Yes No

If no, please explain. _____

How is your energy level? _____

How is your mental awareness? _____

What activities do you do for exercise and how frequently? _____

[MEN ONLY] What was the date and result of your last PSA test, if any?

Date _____ Result _____

[WOMEN ONLY] Do you have periodic mammograms? (circle) Yes No

What was the date and result of your last test?

Date _____ Result _____

Physical Limitations

Do you need assistance when walking? (Circle one) Yes No

Do you require a wheelchair? (Circle one) Yes No

Other requirements _____

What do you intend to accomplish with the treatment you are seeking? _____

Patient's Signature

Date