PATIENT HISTORY FORM

DATE: _____

Please complete this form to the best of your ability. The doctor will review your answers during your visit.

LAST NAME	FIRST	MIDDLE	Date of Birth	AGE	M / F
			/ /		

Primary Care Doctor	Office Number	Last Physical Exam

Height	Weight	*For Weight Loss patients*: Goal Weight	Lowest Adult Weight (after age 18)

Email:	Main Reason for Visit:	Referred by: (website/event/friend/coworker, etc)

MEDICAL & FAMILY HISTORY	**Self**	**Family**		**Self**	**Family**		**Self**	**Family**
Seizures			Asthma/COPD			Diarrhea		
Migraines or Headaches			Sleep Apnea			Liver Disease		
Dizziness			Pulmonary Hypertension			Gallbladder disease/stones		
Loss of Consciousness			Shortness of Breath			Ulcers		
Stroke			Irregular heart rhythm			Colitis		
Glaucoma			Heart Attack or Angina			Constipation		
Thyroid Disorder			Palpitations			Arthritis		
Obesity/Overweight			Heart Valve disorder			Gout		
Diabetes Mellitus (DM)			Heart Failure (CHF)			Osteopenia or Osteoporosis		
High blood sugar			High Blood Pressure			Kidney Disease or stones		
Abnormal Cholesterol			Rheumatic Fever			Alcohol Abuse		
Insomnia			Tuberculosis			Drug Abuse		
Dementia			HIV			Depression or Anxiety		
			Cancer (type: breast, cervical,			Eating Disorder		
Other			Prostate, colon, skin cancer)			Other Psychiatric Illness		

MD Notes:

SURGERIES & HOSPITALIZATIONS

Reason/Diagnosis	Year

SPECIALISTS (If any)

Reviewed by: _____

My Perfect Age Patient Name: _____ DOB: ____/_____/_____

MEDICATION ALLERGIES ☐ *NO KNOWN ALLERGIES*

Name of Medications	Reaction

PRESCRIPTION MEDICATIONS (Including Hormone Supplements)

Medication Name	Dose & Frequency	Approx. Start Date	Reason for use

SUPPLEMENTS & OVER-THE-COUNTER MEDICATIONS

Supplement/Medication Name	Dose & Frequency	Approx. Start Date	Reason for use

SCREENING

TEST	**Last date done**	**Results** ***(-) or state findings***
Blood Sugar, Cholesterol		
Colonoscopy		
PAP Smear (women)		
Mammogram (women)		
Prostate exam, PSA (men)		
Cardiac test *(EKG, echo, stress, etc.)*		
Transvaginal Ultrasound		
HIV, STD		

My Perfect Age Patient Name: _____ DOB: ____/_____/_____

Male & FEMALE patients: Please check all that apply

Respiratory	**NONE**	**MILD**	**MODERATE**	**SEVERE**
Seasonal allergies				
Frequent colds				
Frequent respiratory infections				
Coughing/ wheezing (asthma)				

FEMALE patients only: Please check all that apply

	NONE	**MILD**	**MODERATE**	**SEVERE**
Sleep disorder				
Anxiety/ nervousness				
Irritability				
Depression/emotional swings				
Food cravings				
Hot flashes				
Night sweats				
Vaginal dryness/atrophy				
Urine Leakage				
Dry skin/ wrinkles				
Dry Hair				
Fatigue				
Memory loss				
Concentration loss				
Hair Loss				
Loss of libido/ orgasm				
Muscle weakness/loss				
Muscle and Joint pain				
Loss of pubic hair				

MALE patients only: Please check all that apply

	NONE	**MILD**	**MODERATE**	**SEVERE**
Dry skin				
Dry Hair				
Sleep disorder				
Fatigue				
Memory loss				
Concentration loss				
Anxiety/ nervousness				
Irritability				
Depression				
Loss of libido/ orgasm				
Difficulty maintaining erection				
Difficulty achieving erection				
Premature ejaculation				
Muscle weakness				
Muscle Loss				
Muscle and Joint pain				
Loss of masculinity/confidence/aggressiveness				

My Perfect Age Patient Name: _____DOB: ____/_____/_____

OB/GYN HISTORY (Female patients)

Last Menstrual Period: Age at first onset of period:
If still menstruating: cycle _____ days Circle if (+): Heavy periods, irregularity, spotting or pain
Are you pregnant: NO YES Are you breastfeeding: NO YES Are you trying for a pregnancy: NO YES
Number of pregnancies: Abortions _____ Living children _____ (Vaginal _____ C-section _____) Miscarriages _____
History of Sexual Abuse: NO YES

PERSONAL & SOCIAL HISTORY

Occupation:	Stress level: (0-10)	Education Level: (high school/2 yr degree/ 4yr degree)
Marital Status: # Living Children: _____		Do you feel safe in your relationship: YES NO:
Use of alcohol **NO YES**	If YES, what kind:	How many drinks/week:
Tobacco: If YES, number of years total _____ Past use—quit date: _____Are you ready to quit?_____ **NO YES** Cigarettes packs/day _____ Cigars/day _____ Chew/day _____ Pipe/day _____		
Recreational or street drug use: **NO YES**	If YES, have you ever taken street drugs with a needle: NO YES	
Sexually active **NO YES**	heterosexual bisexual homosexual	*Contraception*: Current method Past method: _____
Hobbies/Interests		

REVIEW OF SYSTEMS

Please check YES to any symptom that you experience. For any YES answer please provide a brief description

	YES	If YES, **list doctor seen**, describe condition and how long
Fever/chills		
Excess fatigue		
Weight loss/gain		
Enlarged lymph nodes		
Frequent bruising		
Blurry vision		
Ringing in ears		
Hearing difficulty		
Mouth sores		
Sinus problems		
Cardiovascular:		
Chest pain at rest or exercise		
Cold hands/ cold feet		
Swelling of legs or ankles		
Calf cramps with exercise		
Shortness of breath with exercise		
Rapid heartbeat at rest		

Gastrointestinal	**YES**	
Constipation		**# bowel movement /day_**
Diarrhea		
Bloating		
Excessive belching		
Gas/acidity		
Blood in stool		
Thirst: Lack of /too much		**# glasses of fluid/day**
Genitourinary		
Pain on urination		
Cloudy/bloody urination		
Urinating too many times		# times per day
Difficulty urinating		
Loss of urine		
Musculoskeletal: ***If YES to any of following questions, please ask for a PAIN RATING scale.***		
Do you see a chiropractor?		
Any regular body treatment/ massage?		
Back Pain		
Neck Pain		
Shoulder Pain		
Arm Pain		
Hip Paint		
Knee Pain		
Other pain		
Muscle point tenderness (pls. describe)		
Skin		
Acne		
Dry Skin		
Oily skin		
Loss of collagen/ firmness		
Wrinkles		
Pigmentation/Scarring		
Any history of skin cancer?		
Do you wear sun block?		
After sun exposure, do you *(circle):*	BURN	Sometimes burn Rarely Burn Never Burn Tan
Cellulite		
Questions on aesthetic services: Botox, Juvederm or lasers?		
Interest in skin care consultation?		
Emotional		
Do you see counselor or psychiatrist?		
Depression		
Anxiety		
Stress		
Neurological		
Weakness in arms, hands, feet or legs		
Numbness or tingling in hands or feet		
Forgetfulness		
Headaches/Migraine headaches		
Dizziness/poor balance		
Memory loss		
Problems with attention		

I have answered the above to the best of my abilities.

Patient Signature:

Nutrition Evaluation

Vegetable intake (pls. circle): < 10% 20-40% 41-60% > 60%
Number of meals per day:
Snacks per day: What snacks & when?
Food Allergies
Food Dislikes
Food(s) you crave Any specific time of day/month you crave food?
Do you awaken hungry during the night? If yes, what do you do? YES NO
Behavior style (***check only one***): ___Always calm & easygoing ___Usually calm & easygoing ___Sometimes calm with frequent impatience ___ Seldom calm and persistently driving for advancement ___ Never calm and have overwhelming ambition ___ Hard-driving and can never relax

	NO	YES		NO	YES	If not you, WHOM?
Partner or spouse overweight?			I plan my meals.			
By how much lbs.			I cook my meals.			
I eat out daily			I shop for food.			
I eat out times/week			I use shopping list for grocery.			
I eat "fast foods" daily			Time of day I usually shop:			
I eat "fast foods" times/wk			I use sugar substitute			Which?
I drink cola drinks.			I use butter.			
I eat when I'm stressed			I use margarine.			
I am currently stressed.			I drink coffee or tea. How many cups/day:			
I skip meals.			I eat on behalf of someone else.			

If Weight Loss is an aim for you, please answer the following questions.	
Goal Weight:	In what time frame would you like to be at your goal weight:
Birth Weight:	Weight one year ago:
Highest weight (non-pregnant) and when:	Lowest Adult Weight (> age 18):
Main reason for your decision to lose weight	
When did you begin gaining excess weight? (Give reasons, if known):	
Previous Diets followed	Approximate date & results of weight loss

Typical Breakfast	Typical Lunch	Typical Dinner
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Time eaten: _____	Time eaten: _____	Time eaten: _____
Where: _____	Where: _____	Where: _____
With whom: _____	With whom: _____	With whom: _____

Activity Level: **(check only one)**

- o Inactive: no regular physical activity with a sit-down job.
- o Light activity: no organized physical activity during leisure time.
- o Moderate activity: occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
- o Heavy activity: consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week.
- o Vigorous activity: participation in extensive physical exercise for at least 60 minutes per session $\geq$ 4 times per week.

What are your top 3 health concerns? Please list in order of importance and how they affect your quality of life:

1. ___ _____
2. _____
3. _____
   _____

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.

Additional NOTES:

Patient Signature: _____