Preventative Medicine Client History

Todays Date: ____

Name: ______________________________ DOB: ______________________ Age:________________________

Address: _____________________________________City/State: ________________ Zip:_______________

Cell #:_____________________ Home #: __________________ Work #: ______________________________

Email:____ _____Female _____ Male

Emergency contact:____________________________________ Phone #:______________________________

How did you hear about us? _____________________________ Occupation: ___________________________

Marital Status: ______________________ Height: ___________________ Weight: ____________________

Allergies: ____

____

MEDICATIONS

Name	Dosage	Frequency

SOCIAL

	Yes	No	Amount
Alcohol use			
Coffee / Tea			
Soft drinks			
Cigarettes			
Chewing tobacco			
High sugar foods			

MEDICAL HISTORY

Condition	Self	Family	Clarification
Arthritis			
Asthma			
Cancer: Breast			
Cancer: Cervical			
Cancer: Ovarian			
Cancer: Prostate			
Cancer: Uterine			
Cancer: Other			
Clotting disorder			
Colitis			
Diabetes			
Fibromyalgia			
Gall Bladder Disease			
Headaches			
Heart Disease			
High Blood Pressure			
HIV / Aids			
Kidney Disease			
Kidney Stones			
Liver Disease			
Mental Disorder			
Osteoporosis			
Seizures			
Stroke			
Thyroid Disorder			
Varicose Veins			

Surgeries: ____

____

____

HORMONE AND VITAMIN SUPPLEMENTATION TAKEN

Check if appicable

	Supplement	Daily Dose		Supplement	Daily Dose
	Calcium			Chromium	
	CoQ10			DHEA	
	Digestive Enzyme			Estradiol	
	Estrace			Estriol	
	Folic Acid			Growth Hormone	
	Iron			Magnesium	
	Melatonin			NCA	
	Pregnenolone			Premarin	
	Probiotic			Progesterone	
	Provera			Selenium	
	Testosterone			Thyroid	
	Vitamin A			Vitamin B3 / Niacin	
	Vitamin E			Zinc	
OTHERS:					

REVIEW OF SYSTEMS

Head	**Check if applicable**
_______ Headaches Frequency	________ Blurred vision
_______ Cloudy vision	________ Far or Near sighted
Hair	
_______ Hair loss	________ Dry hair
_______ Clumps of hair coming out	________ Balding
Cardiovascular	
_______ Water retention	________ Exercise intolerance
_______ Difficult breathing	________ Chest pain while walking
_______ Heaviness in legs	________ Calf muscle cramp often
_______ Heart pounds easily	________ Palpitations
_______ High blood pressure	________ Low blood pressure

Respiratory	Check if applicable	

_______ Shortness of breath	________ Chronic lung congestion
_______ Wheezes	________ Cough
_______ Acute lung congestion	
Gastrointestinal	
_______ Constipation	________ Diarrhea
_______ Heart burn	________ Abdominal pain
_______ Certain foods cause ill feeling after eating	________ Blood in stool
_______ Stomach pain	________ Hernia
Urinary	
_______ Frequent urination	________ Burning with urination
_______ Incontinent issues	________ Dribbling
Musculoskeletal	
_______ Change in muscle mass	________ Joint pain
_______ Limitation in motion	________ Red / inflamed joints
Dermatological	
_______ Dry skin	________ Oily skin
_______ Acne	________ Flaky skin
_______ Cystic acne	
Metabolic	
_______ Difficulty gaining weight	________ Difficulty losing weight
_______ Sensitivity to cold	________ Wake up craving sweets
_______ Fatigue	________ Feel faint
_______ Night sweats	________ Increased thirst
_______ Craves sweets_______ Craves sweets	________ Weight loss more than 10 lbs in 6 months
_______ Weight gain more than 10 lbs. in 6 months	
Psychological	
_______ Rapid mood swings_______ Rapid mood swing	________ Moodiness / change in mood
_______ Depression	________ Lack of self-esteem
_______ Anxiety	________ Difficulty concentrating
________Short attention span________Short attention s	________ Forgetfulness
Sleep	
_______ Difficulty going to sleep	________ Difficulty staying asleep
_______ Wake up frequently	________ Hours of sleep per night

FEMALES ONLY			Page 5
	Bloating and swelling		Breast tenderness
	Miscarriage		Vaginal discharge
	Underactive sex drive		Pelvic soreness
	Menstrual pain		Insomnia
	Vaginal bumps / sores		Irregular period
	Hot flashes		Night sweats
	Vaginal dryness		Infertility
	Heavy menstrual bleeding		Ovarian cysts
	Breast lump		Discomfort with intercourse

Date of last menstrual cycle: ____________________ Date of last pap / pelvic exam:___________________

Date of last mammogram:_______________________ Sexually transmitted disease:____________________

MALES ONLY			
	Pain with ejaculation		Difficulty maintaining erection
	Sexual drive - underactive		Premature ejaculation
	Genital pain		Infertility
	Low sperm count		Discharge from penis
	Rash on penis		Swelling in groin
	Loss of urine control		Frequent urination at night

Date of last prostate exam: _____________________ Sexually transmitted diseases: ____________________

Do you use any medications for sexual diysfunction? ___Yes ___No

If so, please list medication(s)____

What treatments, medications &/or suppliments have you tried and what response did you have:
____
____

Goal /Desired outcome you are looking for: ____
____
____
____

Comments____
____
____
____