 2745 State Road 580 Suite 101

 Clearwater, FL 33761

**Medical History Form**

 Today’s Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**1. Patient Information**:

First Name \_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_Initial \_\_\_\_\_\_\_ Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Apt./suite #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate: \_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home/Work Phone # \_\_\_-\_\_\_\_\_-\_\_\_\_\_ Cell/Alternate: \_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: Male: \_\_\_\_\_\_\_\_\_\_ Female: \_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Medical Conditions/ Diseases:**

Do you have a history of any of the following? Check all that apply:

Cancer ­­\_\_\_\_\_\_Metabolic syndrome \_\_\_\_\_\_ Heart disease \_\_\_\_\_\_ Diabetes\_\_\_\_\_\_ Renal disease \_\_\_\_\_

Osteoporosis \_\_\_\_\_\_\_\_Thyroid disease\_\_\_\_\_\_\_\_\_ Autoimmune disease\_\_\_\_\_\_\_\_\_ Epilepsy\_\_\_\_\_\_\_\_\_ Hormonal issues\_\_\_\_\_\_\_\_ Others \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Family History:**

Do you have family history of \_\_\_\_\_\_\_ Cancer; \_\_\_\_\_\_\_\_ Diabetes; \_\_\_\_\_\_\_ Autoimmune Diseases;

\_\_\_\_\_\_\_\_\_ Cardio Vascular Diseases; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Others

**4. Lifestyle Information:**

 a) Do you use tobacco? Yes \_\_\_\_\_No \_\_\_\_\_ If yes, how often and how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b) Do you use Alcohol? Yes \_\_\_\_\_No \_\_\_\_\_ If yes, how often and how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c) Do you use Caffeine? Yes \_\_\_\_\_No \_\_\_\_\_ If yes, how often and how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

d) Exercise: Do you exercise? Yes \_\_\_ No\_\_\_ If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

e) Stress Management: Do you practice any stress management techniques? Yes\_\_\_ No\_\_ If yes, specify what type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

f) Diet: Describe your typical daily food intake:

First Meal: Second Meal: Third Meal: Any snacks/other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weight loss/gain in the last year? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_lbs

**5. Allergies:**

Please check all that apply: \_\_\_\_\_\_ no known allergies; \_\_\_\_\_\_\_ Lidocaine/Novocain\_\_\_\_\_\_\_\_\_ dye; \_\_\_\_\_\_\_ pet allergies; \_\_\_\_\_\_\_steroidal drugs; \_\_\_\_\_\_ aspirin; \_\_\_\_\_\_\_\_ seasonal (pollen) allergies; \_\_\_\_\_\_\_\_\_\_\_\_mold/dust; \_\_\_\_\_\_\_\_sulfa drug food allergies; \_\_\_\_\_\_\_\_\_penicillin; \_\_\_\_\_\_Benadryl;

other chemicals \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If applicable, please describe any allergic reaction you experienced and when it occurred:\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. Nutritional/Natural Supplements:**

Please identify and list any products you are using

Vitamins:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Minerals:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Herbal formulas:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nutrition/protein supplements:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7. Over-the-counter (OCT) medication:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8. Prescription Medications:**

 Please list all prescription medications you are currently using. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**9. Hormonal Replacement Therapy:**

Please list all hormone replacement therapy you are currently using.

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**10. Doctor Information:**

 Are you currently under the care of a physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_\_\_\_\_ No

If yes, please list each doctor from whom you seek care, including address and phone number, if known:

Doctor’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you experienced any of the following symptoms recently? Please circle the number

 **MILD MODERATE SEVERE**

Sleep Disruptions 1 2 3 4 5 6 7 8 9 10

Fatigue 1 2 3 4 5 6 7 8 9 10

Vaginal Dryness (female) 1 2 3 4 5 6 7 8 9 10

Irritability 1 2 3 4 5 6 7 8 9 10

Nervousness 1 2 3 4 5 6 7 8 9 10

Breast Tenderness 1 2 3 4 5 6 7 8 9 10

Hot Flashes 1 2 3 4 5 6 7 8 9 10

 Dry Skin 1 2 3 4 5 6 7 8 9 10

Mood Swings 1 2 3 4 5 6 7 8 9 10

 Arthritis/Joint Pain 1 2 3 4 5 6 7 8 9 10

Loss of Recent Memory 1 2 3 4 5 6 7 8 9 10

Weight Gain 1 2 3 4 5 6 7 8 9 10

 Decreased Sex Drive 1 2 3 4 5 6 7 8 9 10

Depression 1 2 3 4 5 6 7 8 9 10

 Fluid Retention 1 2 3 4 5 6 7 8 9 10

Headaches 1 2 3 4 5 6 7 8 9 10

Night Sweats 1 2 3 4 5 6 7 8 9 10

Hair Loss 1 2 3 4 5 6 7 8 9 10

Harder to Reach Climax 1 2 3 4 5 6 7 8 9 10

Bladder Symptoms 1 2 3 4 5 6 7 8 9 10

Constipation 1 2 3 4 5 6 7 8 9 10

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1 2 3 4 5 6 7 8 9 10

Patient signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_