Patient Medical History Form

How did you hear about us?

Full Name

First Name Last Name

Phone Number

Area Code - Phone Number

Mailing Address plus City, State, Zip

Date of Birth

SSN or Drivers License #

E-mail

Primary Care Provider

Primary Care Provider Phone

List prescription medications, including vitamins and supplements that you are taking:

Drug sensitivities and/or drug allergies:

What is your Gender?

- Male
- Female

Height

Weight

Check Yes or No for Each

	Personal History? Yes	Personal History? No	Family History? Yes	Family History? No
Heart Failure/Heart Attack				
Atrial Fibrillation (arrhythmia)				
Heart valve disorders				
Stent				
Hypertension				
Clotting Disorders				
Stroke				
Anemia				
Thyroid Disease				
Diabetes				
Cholesterol Problems				
Breast Cancer				
Ovarian Cancer				
Uterine Cancer				
Skin Cancer				

Prostate Cancer	☐	☐	☐	☐
Prostate Problems	☐	☐	☐	☐
Erectile Dysfunction	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Asthma/COPD	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Orthopedic or muscle disorders	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐
Back problems	☐	☐	☐	☐
Gastrointestinal ulcers	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐

Please list any hospitalizations and/or surgeries or any additional information regarding your health:

Do you drink alcohol?

If so, how often?

Do you smoke?

If so, how often?

Do you exercise?

If so, how often?

FOR MALE PATIENTS ONLY

History of hormone

replacement therapy (HRT)?

Any adverse effects from HRT?

Are you currently on HRT?

If yes, in what form?

What is the dosage and frequency?

When is the last time you took the above mentioned medication?

Please rate on a scale from 1-5 the following with 1 being the worst and 5 being the best

Mood

	1	2	3	4	5	
Worst	○	○	○	○	○	Best

Energy

	1	2	3	4	5	
Worst	○	○	○	○	○	Best

Libido

	1	2	3	4	5	
Worst	○	○	○	○	○	Best

FOR FEMALE PATIENTS ONLY

Currently pregnant?

History of hormone replacement therapy

(HRT)?

Any adverse effects from HRT?

Are you currently on HRT?

If yes, in what form?

What is the dosage and frequency?

When is the last time you took the above mentioned medications?

Click to edit

Have you ever had a hysterectomy?

If so, total or partial? When?

Form of contraception, if any?

Date of last period? Normal?

Last mammogram? Normal?

Last pap smear? Normal?

Please seleect yes or no if you are experiencing any of the following symptoms, regardless of if you are on hormone replacement therapy or not:

	Yes	No
Hot flashes	○	○
Night sweats	○	○
Vaginal dryness	○	○
Mood swings	○	○

Breast tenderness	○	○
Sleep disturbances	○	○
Water retention	○	○
Dry skin/Dry hair	○	○

Please rate on a scale from 1-5 the following with 1 being the worst and 5 being the best

Mood

	1	2	3	4	5	
Worst	○	○	○	○	○	Best

Energy

	1	2	3	4	5	
Worst	○	○	○	○	○	Best

Libido

	1	2	3	4	5	
Worst	○	○	○	○	○	Best

FOR BOTH MEN AND WOMEN

Please select yes or no if you are experiencing any of the following symptoms, regardless if you are on hormonereplacement therapy or not.

	Yes	No
Decreased desire and ability to exercise	○	○
Fatigue	○	○
Decreased sense of well being	○	○
Increasingly stressed	○	○
Decreasing memory or ability to focus	○	○
Decreasing loss of lean muscle mass	○	○
Increased fat deposits	○	○

Loss of concentration	○	○
Difficulty sleeping	○	○
Thinning or loss of hair	○	○
Hot flashes	○	○
Weight gain	○	○
Weight loss	○	○
Mood swings	○	○
Pain in muscles or joints	○	○
Decreased interest in sex	○	○
Inability or decreased ability to maintain an erection	○	○

Date

Month - Day - Year

Signature