

# MEDICAL HISTORY FORM

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender:  M  F

**SYMPTOMS:** Please check if you are experiencing any of the following:

**Men and Women:**

- Decreased Energy/Stamina
- Decreased Sex Drive
- Difficulty Concentrating
- Lack of Mental Clarity
- Decreased Short-Term Memory
- Difficulty Sleeping
- Irritability or Grumpiness
- Sadness or Depression

**Men and Women:**

- Anxiety
- Decreased Motivation
- Weight Gain or Excess Fat
- Loss of Muscle Mass or Strength
- Decreased Response to Exercise
- Joint Pain or Muscle Aches
- Migraine/Severe Headaches
- High Cholesterol

**Men Only:**

- Weak Erections

**Women Only:**

- Hot Flashes
- Night Sweats
- Vaginal Dryness
- Sagging Breasts
- Fibrocystic Breasts

**MEDICAL HISTORY:** Please check if you have or have had any of the following:

**Men and Women:**

- HIV Positive
- Hepatitis or Liver Disease
- Thyroid Condition
- Diabetes
- High Blood Pressure
- Heart Disease
- Kidney Disease

**Men and Women:**

- Rheumatic Fever
- Mitral Valve Prolapse
- Heart Murmur
- Osteoporosis
- Psychiatric Condition
- Phlebitis or Blood Clots
- Hair Loss

**Men Only:**

- Prostate Enlargement
- Prostate Cancer

**Women Only:**

- Breast Cancer
- Uterine Fibroids
- Uterine Cancer

**Men Only:** Date of Last Prostate Exam: \_\_\_\_\_ Results: \_\_\_\_\_

**Women Only:** Do you still have periods?  Yes  No First Day of Last Period: \_\_\_\_\_

Date of Last Mammogram: \_\_\_\_\_ Results: \_\_\_\_\_

Date of Last PAP Smear: \_\_\_\_\_ Results: \_\_\_\_\_

**ILLNESSES OR CONDITIONS FOR WHICH YOU ARE CURRENTLY UNDER A DOCTOR'S CARE:**

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**PREVIOUS OPERATIONS INCLUDING HYSTERECTOMY AND COSMETIC SURGERY:**

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# MEDICAL HISTORY FORM cont'd

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**CURRENT MEDICATIONS AND DOSAGES:** Prescription and non-prescription, including birth-control pills, aspirin, herbs, and vitamins:

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**ALLERGIES:** Medication or other: \_\_\_\_\_

**GOALS OF TREATMENT:** Please check any of the following that you would like to achieve:

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|--|--|
| <input type="checkbox"/> Have more energy  | <input type="checkbox"/> No longer use sleep medication            |
| <input type="checkbox"/> Sleep well  | <input type="checkbox"/> Feel less sleepy in the afternoon         |
| <input type="checkbox"/> Have better digestion   | <input type="checkbox"/> Lose weight                               |
| <input type="checkbox"/> Be able to eat a greater variety of foods                     | <input type="checkbox"/> Increase my sex drive                     |
| <input type="checkbox"/> Get rid of my allergies                                       | <input type="checkbox"/> Have less hot flashes and/or night sweats |
| <input type="checkbox"/> Have a stronger immune system<br>(e.g., less colds and flues) | <input type="checkbox"/> Increase my metabolism to burn more fat   |
| <input type="checkbox"/> No longer use laxatives or stool softeners                    | <input type="checkbox"/> Increase my flexibility                   |
| <input type="checkbox"/> Be able to exercise again                                     | <input type="checkbox"/> Reduce my stress                          |
| <input type="checkbox"/> Have better muscle tone                                       | <input type="checkbox"/> Improve my memory                         |
| <input type="checkbox"/> Have less pain  | <input type="checkbox"/> Be more mentally focused                  |
| <input type="checkbox"/> No longer use pain medication                                 | <input type="checkbox"/> Have more stable moods                    |
| <input type="checkbox"/> No longer use allergy medication                              | <input type="checkbox"/> Have stronger erections                   |
|  | <input type="checkbox"/> Have fewer headaches                      |

**HEALTH RATING:** With 1 being "poor" and 10 being "excellent," on a scale of 1-10, please circle below how you would rate your overall health:

1 2 3 4 5 6 7 8 9 10

**QUESTIONS AND CONCERNS:** Please write down the items you would like to discuss with the doctor:

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**SIGNATURES:**

\_\_\_\_\_  
Patient

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Doctor