

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:

PREVIOUS OPERATIONS INCLUDING HYSTERECTOMY AND COSMETIC SURGERY:

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

ALLERGIES: Medication or other: _____

Patient Signature

Physician Signature