Vitality Aesthetic & Regenerative Medicine

2595 Tampa Road, Suite P, Palm Harbor, FL 34684

Medical Health Questionnaire

- ❑ **New Patient**
- ❑ **Name Change**
- ❑ **Address Change**
- ❑ **Insurance Change**

ALL SECTIONS MUST BE COMPLETED FOR ALL PATIENTS:

Today's Date:____/____/____
Patient Name:
_____

Last First Middle

Initial:_____

Date of Birth: _____/_____/_____ **Age:** _____ **Sex**: Male Female

Mailing Address:
_____

Street City State Zip

Secondary Address:
_____

Street City State Zip

Home Phone: ( ) _____ **Work Phone: ( )**_____**Cell Phone: ( )** _____

Emergency Contact Name & Phone: ( )_____

Email Address_____

Primary Care Physician:_____

Referred by:_____

Reason For Visit? _____

How Did You Hear About Us?_____

Lifestyle Factors:

Occupation:_____Hours worked per week?_____

Marital Status: Single Married Divorced Widowed Separated

Physical Activity

Type:	Duration:	Intensity:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Sleep:

How many hours per night do you sleep?_____

Do you wake up often?_____

If so, how many times?_____

Reason for waking?_____

Stress:

Do you experience an unusual amount of stress on a daily basis?_____

Methods used to relieve stress?_____

Weight History:

Height: _____ Current Weight: _____ Highest Weight _____

Ideal Weight _____

Family Medical History: (Circle all that apply)

High Blood Pressure Heart Attack Stroke Blood Clots Bleeding Tendencies

Diabetes Glaucoma Muscular Degeneration Osteoporosis Breast Cancer

Colorectal cancer Thyroid Disorder Depression Bipolar Manic Depressive

Alcohol Abuse Substance Abuse Dementia or Alzheimer's Disease Celiac

Surgeries or Hospitalizations:

Year_____Reason_____

Year_____Reason_____

Major Illness or Injuries:

Year_____Reason_____

Year_____Reason_____

Personal Medical History (Circle all that apply):

Endocrine: Thyroid Disease Adrenals Pituitary Diabetes

Respiratory: Asthma Emphysema Pulmonary Emboli

Musculoskeletal: Arthritis Osteoporosis Back or Spine Problems Carpal Tunnel

Mental Health: Depression Anxiety Schizophrenia ADHD Bipolar
Substance Abuse Alcoholism

Genitourinary: Kidney Stones Impotence Infertility Menopause Fibroids
Ovarian Cyst Polycystic Ovarian Syndrome Endometriosis

Gastrointestinal: Ulcers Malabsorption Diverticulosis Hepatitis Liver Disease
Lactose Intolerance

Cardiac Concerns: Heart Attack Angina Arrhythmia High Blood Pressure
Heart Murmur High Cholesterol

Cancer: Type: _____When:_____

General: Glaucoma Epstein-Barr Chronic Fatigue

Neurology: Seizures Headaches Migraines Stroke

Social History:
Do you smoke? _____
If so, what type:_____
How much do you smoke?_____
Do you want to quit?_____
Do you drink alcohol?_____
If so, how many drinks per week?_____
What do you drink? _____
Do you drink caffeine products (coffee, tea, energy
drinks,soda)?_____

How many per day?_____
Date of last physical exam? _____
Date of last PSA or prostate exam? _____
Date of last Pap smear/pelvic exam? _____
Date of last mammogram? _____
(Women) Have you had a hysterectomy?_____
(Men) Have you had a vasectomy?_____

Medications (please list all prescription and non-prescription medications and nutritional supplements):
Name:_____Dosage:_____Frequency _____

Name:_____Dosage:_____Frequency _____

Name:_____Dosage:_____Frequency _____

Name:_____Dosage:_____Frequency _____

Name:_____Dosage:_____Frequency _____

Name:_____Dosage:_____Frequency _____

Allergies:_____
_____
_____

Typical daily food intake:

	Weekdays	**Weekends**

Breakfast::_____
_____
Morning
Snack:_____
_____
Lunch:_____
_____
Afternoon:
Snack:_____
_____
Dinner:_____
_____
Evening
Snack:_____
_____

Midnight
Snack:_____
_____

Hormone Questionnaire for **WOMEN** Only:

Symptom	**None**	**Mild**	**Moderate**	**Severe**
Night Sweats				
Vaginal Dryness				
Incontinence				
Bleeding Changes				
Uterine Fibroids				
Water Retention				
Breast tenderness				
Fibrocystic Breast				
Increased Forgetfulness				
Foggy Thinking				
Tearful				
Depressed				
Mood Swings				
Difficulty Sleeping				
Decreased Stamina				
Anxious				
Irritable				
Nervous				
Fibromyalgia				
Allergies				
Headache				
Sugar Cravings				
Dizzy Spells				
Cold Body Temperature				
Goiter				
Hoarseness				
Dry and Brittle Hair				
Nails Breaking and Brittle				
Constipation				

Slow Pulse Rate				
Rapid Heart				
Heart Palpitations				
Infertility				
Acne				
Increased Facial/Body Hair				
Scalp Hair Loss				
Weight Gain Hips				
Weight Gain Waist				
High Cholesterol				
Elevated Triglycerides				
Decreased Libido				
Decreased Muscle Size				
Thinning Skin				
Ringing in Ears				
Rapid Aging				
Aches and Pains				
Bone Loss				
Decreased Urine Flow				
Decreased Urinary Urge				

Hormone Questionnaire for **MEN** Only:

Symptom	**None**	**Mild**	**Moderate**	**Severe**
Prostate Problems				
Weight Gain Chest/Hips				
Weight Gain WASITE				
Decreased Libido				
Low Androgens				
Decreased Erections				
Ringing in Ears				
High Cholesterol				
Elevated Triglycerides				
Hot Flashes				
Night Sweats				

Decreased Mental Sharpness				
Increased Forgetfulness				
Decreased Muscle Size				
Decreased Flexibility				
Sore Muscles				
Increased Join Pain				
Bone Loss				
Rapid Aging				
Thinning Skin				
Decreased Stamina				
Burned Out Feeling				
Stress				
Morning Fatigue				
Evening Fatigue				
Difficulty Sleeping				
Apathy				
Depressed				
Mental Fatigue				
Anxious				
Irritable				
Nervous				
Headaches				
Sugar Cravings				
Dizzy Spells				
Cool Body Temperature				
Goiter				
Hoarseness				
Dry or Brittle Hair				
Constipation				
Slow Purse Pate				
Rapid Heart Rte				
Heart Palpitations				
Infertility Problems				
Allergies				