

**Balance Health & Wellness Center  
Patient Intake Form**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Gender:  Male  Female Occupation: \_\_\_\_\_

Medication allergies: \_\_\_\_\_

Primary care physician: \_\_\_\_\_

Gynecologist: \_\_\_\_\_

Other physicians: \_\_\_\_\_

Do you wish for Dr. Edwards to send copies of your test reports or office visits to any of your other physicians? \_\_\_\_\_ Who? \_\_\_\_\_

Previous anti-aging physicians seen: \_\_\_\_\_

How did you hear about this practice: \_\_\_\_\_

**Medications (dose & frequency)**

**Medical History & Previous Surgeries:**

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**Family Members Medical History**

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Sister(s): \_\_\_\_\_

Brother(s): \_\_\_\_\_

Maternal Grandparents: \_\_\_\_\_

Paternal Grandparents: \_\_\_\_\_

**Please list all over the counter medications, supplements, herbs you take:**

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**Have you ever been on any hormonal therapies (name, duration, prescribing MD):**

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**Have you previously undergone testing of your hormones? What type of testing?**

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**Caffeine:**  No  Yes: how much & how long? \_\_\_\_\_

**Nicotine:**  No  Yes: how much & how long? \_\_\_\_\_

**Illicit drugs:**  No  Yes: how much & how long? \_\_\_\_\_

**Alcohol:**  No  Yes: how much & how long? \_\_\_\_\_

**How would you describe your typical daily diet?**

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**Frequency and type of exercise:** \_\_\_\_\_

**How many hours of *uninterrupted* sleep do you get per night:** \_\_\_\_\_

**How would you describe your current stress level?** \_\_\_\_\_

**What are the top three most stressful situations/circumstances currently affecting you?**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Have you ever had counseling/psychotherapy? If so, when?**

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**What steps have you taken to reduce or alter the stressors affecting your health?**

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**Preventative Health/Other Testing Done:**

	Date		Date
1. Mammogram	_____	6. Pap smear	_____
2. Colonoscopy	_____	7. Bone density	_____
3. Breast exam	_____	8. Cholesterol	_____
4. PSA	_____	9. Prostate exam	_____
5. Pelvic ultrasound	_____	10. Sleep study	_____

**Symptoms: Check all that apply and give additional pertinent details**

**General**

- Hot flashes \_\_\_\_\_
- Headaches \_\_\_\_\_
- Night sweats \_\_\_\_\_
- Bladder leakage \_\_\_\_\_
- Fluid retention \_\_\_\_\_
- Fatigue \_\_\_\_\_
- Decreased energy \_\_\_\_\_
- Decreased stamina \_\_\_\_\_
- Acne/oily skin \_\_\_\_\_
- Excessive facial hair \_\_\_\_\_
- Hair loss \_\_\_\_\_
- Palpitations \_\_\_\_\_
- Weight gain \_\_\_\_\_
- Sugar cravings \_\_\_\_\_
- Loss of memory \_\_\_\_\_
- Joint pain \_\_\_\_\_
- Thinning skin \_\_\_\_\_
- Heat/cold intolerance \_\_\_\_\_
- Erectile problems \_\_\_\_\_
- Lack muscle tone \_\_\_\_\_
- Salt cravings \_\_\_\_\_
- Fingernail changes \_\_\_\_\_
- Dry skin \_\_\_\_\_

**Mood**

- Depression \_\_\_\_\_
- Irritability \_\_\_\_\_
- Anxiety \_\_\_\_\_
- Poor concentration \_\_\_\_\_
- Cannot fall asleep (When do you go to bed? \_\_\_\_\_; When do you fall asleep? \_\_\_\_\_)
- Can't stay asleep (What wakes you? \_\_\_\_\_; How often? \_\_\_\_\_)
- Low sex drive \_\_\_\_\_
- Thoughts of harming self or others \_\_\_\_\_

**Gastrointestinal**

- Constipation (How often, when, exacerbating factors? \_\_\_\_\_)
- Diarrhea (How often, when, exacerbating factors? \_\_\_\_\_)
- Indigestion (Describe: \_\_\_\_\_)
- Cramping (Describe: \_\_\_\_\_)
- Nausea/vomiting (Describe: \_\_\_\_\_)

**Menstrual/Gynecologic**

- Vaginal dryness
- Irregular bleeding \_\_\_\_\_
- Spotting in between periods (How long? \_\_\_\_\_)
- Endometriosis (how diagnosed? \_\_\_\_\_)
- Breast pain (Continuous vs. cyclic? \_\_\_\_\_)
- Fibrocystic breasts \_\_\_\_\_
- Low sex drive \_\_\_\_\_
- Infertility/Difficulty getting pregnant \_\_\_\_\_

**Please rate your average daily energy level on a scale of 1-10 (1=low; 10=high):**

8:00 am \_\_\_\_\_ 12:00 pm \_\_\_\_\_ 4:00 pm \_\_\_\_\_ 8:00 pm \_\_\_\_\_

At what point during the day do you feel the best? \_\_\_\_\_

At what point during the day do you feel the worst? \_\_\_\_\_

**What are your expectations and in what way do you want Dr. Edwards to help you?**

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