



Patient Intake Form

Name: _____ DOB: _____ Age: _____
Address: _____ City: _____ Zip: _____
Phone: _____ Gender: Male Female

Medication allergies: _____

Primary care MD/Gyn: _____

Previous anti-aging physicians seen: _____

How did you hear about this practice: _____

Medications (dose & frequency)

Medical problems/Surgeries:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History:

Mother: _____

Father: _____

Sister(s): _____

Brother(s): _____

Over the counter medications, supplements, herbs:

_____	_____
_____	_____
_____	_____

Previous hormone therapies (name, date started, duration):

Previous hormone testing, is so, what type?:

Caffeine: No Yes: how much? _____

Nicotine: No Yes: how much? _____

Alcohol: No Yes: how much? _____

How would your typical daily diet?

Amount and type of exercise: _____

How many hours to you sleep per night: _____

How would you rate your level of stress on a scale of "1 to 10"? _____

Preventative Health:

	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	_____		

Symptoms (check all applicable):

<input type="checkbox"/> Hot flashes	<input type="checkbox"/> Breast pain	<input type="checkbox"/> Endometriosis
<input type="checkbox"/> Headaches	<input type="checkbox"/> Irregular bleeding	<input type="checkbox"/> Night sweats
<input type="checkbox"/> Bladder leakage	<input type="checkbox"/> Fluid retention	<input type="checkbox"/> Poor concentration

- | | | |
|--|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Can't fall asleep |
| <input type="checkbox"/> Low sex drive | <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Acne/oily skin |
| <input type="checkbox"/> Excessive facial hair | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Can't stay asleep |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Sugar cravings |
| <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Decreased energy | <input type="checkbox"/> Decreased stamina | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Thinning skin | <input type="checkbox"/> Heat/cold intolerance | <input type="checkbox"/> Erectile problems |
| <input type="checkbox"/> Fibrocystic breasts | <input type="checkbox"/> Lack muscle tone | <input type="checkbox"/> Salt cravings |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Fingernail changes | <input type="checkbox"/> Dry skin |

Average daily energy level on a scale of 1-10:

8:00 am _____ **12:00 pm** _____ **4:00 pm** _____ **8:00 pm** _____

What are your expectations and what do you hope to achieve by enrolling in this clinic?
