

Patient Name: _____ Date: _____

Face Sheet

Today's Date: _____

Name: _____

Gender: M ___ F ___ DOB: _____ Age: _____

Physical
Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Hm# _____ Wk# _____ Cell# _____

Social Security# _____ E-mail Address: _____

Whom may we thank for your referral? _____

Comments:

Patient Name: _____ Date: _____

Medical History

Today's Date: _____

Occupation: _____ Height: _____ Weight: _____

Medical Conditions/Diseases/Testing:

Overall how would you rate your health? Excellent___ Good___ Fair___ Poor___

How do you rate your energy level? High___ Average___ Low___ Poor___

How do you rate your stress level? Ideal___ Good___ Tolerable___ High___

How often do you exercise every week? 3+ times___ Twice___ Once___ Rarely___

What type of exercise do you do? Aerobic___ Anaerobic/Strengthening___ Both___

Walking/low impact ___

Do you have any medical conditions? Please check all that apply to you.

- Arthritis or Joint Problems Blood Clotting Problems Cancer
- Depression Diabetes Epilepsy
- Headaches/Migraines Heart Disease High Blood Pressure
- High Cholesterol or lipids Hormonal Related Issues Immune System disorders
- Lung condition/Asthma Thyroid Disease Ulcers
- Others: _____

What surgeries have you had, and in what year?

Patient Name: _____ Date: _____

Current Prescription Medication(s):

Medication Name: _____ Strength: _____

Date Started: _____ How often per day?: _____

Medication Name: _____ Strength: _____

Date Started: _____ How often per day?: _____

Medication Name: _____ Strength: _____

Date Started: _____ How often per day?: _____

Medication Name: _____ Strength: _____

Date Started: _____ How often per day?: _____

Medication Name: _____ Strength: _____

Date Started: _____ How often per day?: _____

List Hormones Previously Taken:

Hormone: _____

Date Started _____ Date Stopped _____ Reason: _____

Hormone: _____

Date Started _____ Date Stopped _____ Reason: _____

Hormone: _____

Date Started _____ Date Stopped _____ Reason: _____

Over-the-counter (OTC) Issues: Please check all products that you use occasionally or regularly. Check all that apply.

___ Acetaminophen (Tylenol®)

___ Antacids (Tagamet HB®, Pepcid C®, Zantac 75®)

___ Antidiarrheals (Imodium®, Pepto Bismol®, Kaopectate®)

___ Antihistamine product (Chlor-Trimeton®)

___ Aspirin

___ Cough Suppressant (Chlor-Trimeton®)

___ Diet aids/weight loss products (Dexatril®)

___ Ketoprofen (Robitussin DM®)

___ Naproxen (Aleve®)

___ Pain Reliever

___ Sleep aids (Excedrin PC®, Ulnisom®, Sominex®, Nytol®)

Patient Name: _____ Date: _____

Nutritional/Natural Supplements: Please identify and check the products you are using:

- Enzymes (eg: digestive formulas, papaya, bromelain, Coenzyme Q10, etc.)
- Herbs (eg: Ginseng, Ginko Biloba, Echinacea, other herbal medicinal teas, tinctures, remedies, etc.)
- Minerals (eg: calcium, magnesium, chromium, colloidal minerals, various single minerals)
- Nutrition/proteinsupplements (eg: shark cartilage, protein powders, amino acid, fish oils, etc.)
- Vitamins (eg: multiple or sing vitamins such as B complex, E, C beta carotene)
- Others (glucosamine, etc.)

Allergies: Please check all that apply.

- | | | |
|--|--|--|
| <input type="checkbox"/> No known allergies | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Dye Allergies | <input type="checkbox"/> Food Allegies | <input type="checkbox"/> Morphine |
| <input type="checkbox"/> Nitrate Allegries | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Pet Allergies |
| <input type="checkbox"/> seasonal (pollen) allergies | | <input type="checkbox"/> Sulfa Drug |
| <input type="checkbox"/> Others: _____ | | |

Please describe the allergic reaction you experienced and when it occurred

Patient Name: _____ Date: _____

Family History

Parents/Children

Mother: Age: _____ Condition: _____

Father: Age: _____ Condition: _____

Sister(s): Female: ___ Age(s): _____ Condition(s): _____

Brother(s): Male ___ Age(s): _____ Condition(s): _____

Child/Children: Male ___ Female: ___ Age(s): _____ Condition(s): _____

Child/Children: Male ___ Female: ___ Age(s): _____ Condition(s): _____

Child/Children: Male ___ Female: ___ Age(s): _____ Condition(s): _____

Patient Name: _____ Date: _____

Do you have any family history of any of the following? (Relation with the family member)

Allergies/Asthma	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Parent	<input type="checkbox"/> Child	<input type="checkbox"/> Sibling	<input type="checkbox"/> Grandparent
Arthritis	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Parent	<input type="checkbox"/> Child	<input type="checkbox"/> Sibling	<input type="checkbox"/> Grandparent
Breast cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Parent	<input type="checkbox"/> Child	<input type="checkbox"/> Sibling	<input type="checkbox"/> Grandparent
Dementia/Alzheimer's	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Parent	<input type="checkbox"/> Child	<input type="checkbox"/> Sibling	<input type="checkbox"/> Grandparent
Depression	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Parent	<input type="checkbox"/> Child	<input type="checkbox"/> Sibling	<input type="checkbox"/> Grandparent
Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Parent	<input type="checkbox"/> Child	<input type="checkbox"/> Sibling	<input type="checkbox"/> Grandparent
Fibrocystic Breast	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Mother	<input type="checkbox"/> Child	<input type="checkbox"/> Sister	<input type="checkbox"/> Grandmother
Heart Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Parent	<input type="checkbox"/> Child	<input type="checkbox"/> Sibling	<input type="checkbox"/> Grandparent
Hypertension	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Parent	<input type="checkbox"/> Child	<input type="checkbox"/> Sibling	<input type="checkbox"/> Grandparent
Obesity	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Parent	<input type="checkbox"/> Child	<input type="checkbox"/> Sibling	<input type="checkbox"/> Grandparent
Osteoporosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Parent	<input type="checkbox"/> Child	<input type="checkbox"/> Sibling	<input type="checkbox"/> Grandparent
Ovarian Cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Mother	<input type="checkbox"/> Child	<input type="checkbox"/> Sister	<input type="checkbox"/> Grandmother
Prostate Cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Father	<input type="checkbox"/> Son	<input type="checkbox"/> Brother	<input type="checkbox"/> Grandfather
Skin Conditions	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Parent	<input type="checkbox"/> Child	<input type="checkbox"/> Sibling	<input type="checkbox"/> Grandparent
Stroke	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Parent	<input type="checkbox"/> Child	<input type="checkbox"/> Sibling	<input type="checkbox"/> Grandparent
Uterine Cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Mother	<input type="checkbox"/> Child	<input type="checkbox"/> Sister	<input type="checkbox"/> Grandmother

Patient Name: _____ Date: _____

Energy Level

Rate your energy level on a scale from 1 to 10, where 1=low and 10=full or energy: _____

**For all following YES/NO questions, please understand that NO is always first and YES second.
In some cases, the questions may appear "backwards"**

Do you have difficulty handling stress?	No	Yes
Has your energy level dropped?	No	Yes
Do you have energy swings?	No	Yes
Do you feel better after you eat?	No	Yes
Do you feel better after your evening meal?	No	Yes
Do you feel tired and fatigued?	No	Yes
Do you have salt cravings?	No	Yes
Do you have sweet cravings?	No	Yes
Are you run down in the afternoon? (3 to 4pm)	No	Yes
Do you stay up late?	No	Yes
Do you wake up tired?	No	Yes
How long have you felt this way? _____		

Patient Name: _____ Date: _____

Thyroid

Please check all that apply: are you or do you have (at least sometimes)

- | | | | |
|---|--------------------------------------|---|---|
| <input type="checkbox"/> constipated | <input type="checkbox"/> depressed | <input type="checkbox"/> fatigued | <input type="checkbox"/> intolerant to heat |
| <input type="checkbox"/> intolerant to cold | <input type="checkbox"/> nervous | <input type="checkbox"/> not sleeping well at night | <input type="checkbox"/> palpitations? |
| <input type="checkbox"/> skin dry | <input type="checkbox"/> weight gain | <input type="checkbox"/> weight loss | |

Other: _____

Have you ever been diagnosed with a thyroid problem? No Yes

Are you on thyroid replacement? No Yes

Dose: _____

Medications: _____

Weight Control

Do you gain weight easily? No Yes

Have you had any significant weight gain? No Yes

Do you have difficulty losing weight? No Yes

Have you had weight loss? No Yes

Do you put on weight around your thighs? No Yes

Do you put on weight around your waist? No Yes

How much and over what period of time? _____

Patient Name: _____ Date: _____

Mood / Sleep

Do you feel depressed? No Yes
 How often? _____

For how long? _____

Are you on antidepressants? No Yes
 Which ones? _____

Dose: _____

Are you anxious, nervous? No Yes
 Do you have difficulty setting goals? No Yes
 Are you less confident? No Yes

How many hours to you sleep each night? _____

Do you use a sleep aid? No Yes
 What dose? _____

Do you NOT sleep well at night? No Yes
 Do you need a lot of sleep? No Yes
 Do you stay up late? No Yes
 Are you STILL TIRED when you wake up in the A.M.? No Yes
 Do you have trouble falling asleep? No Yes
 Do you wake up at night? No Yes
 Do you wake up tired? No Yes

Patient Name: _____ Date: _____

MSK

Do you have arthritis? No Yes

Do you have low back pain? No Yes

Do you have muscle pain? No Yes

Do you have osteoarthritis? No Yes

Do you have osteoporosis? No Yes

Do you have stiffness? No Yes

Where? _____

Patient Name: _____ Date: _____

FOR WOMEN ONLY

Have you had any of the following tests performed? Check those that apply and note date of the last test.

Mammography: No ___ Yes ___ When? _____ Normal ___ Abnormal ___
 PAP Smear: No ___ Yes ___ When? _____ Normal ___ Abnormal ___
 Bone Density: No ___ Yes ___ When? _____ Normal ___ Abnormal ___

Do you have:

Anxiety	No	Yes
Bloating	No	Yes
Breast Tenderness	No	Yes
Cravings	No	Yes
Crying	No	Yes
Depression	No	Yes
Facial Hair	No	Yes
Fatigue	No	Yes
Fluid Retention	No	Yes
Headaches	No	Yes
Heart Palpitations	No	Yes
Hot Flashes	No	Yes
Insomnia	No	Yes
Irritability	No	Yes
Menstrual Cramps	No	Yes
Mood Swings	No	Yes
Night Sweats	No	Yes
Weight Gain	No	Yes

Patient Name: _____ Date: _____

Menstrual Periods

What was the date of your last normal menstrual cycle? _____

At what age did your periods starts? _____

Do you have missed periods? No Yes

How long is your cycle? _____

Is it IRRegular? No Yes

Birth Control: check all that apply:

"natural" _____ IUD _____ pill _____ none _____

Hormones:

Are you currently taking estrogen? No Yes

Are you currently taking progesterone? No Yes

Have you ever taken Depo-Provera? No Yes

If any yes, when/how long?

Patient Name: _____ Date: _____

Bladder/Ovaries/Vagina/Uterus

Do you get recurrent bladder infections?	No	Yes
Have you had endometriosis?	No	Yes
Have you had a hysterectomy?	No	Yes
Have you had ovarian cysts?	No	Yes
Were your ovaries removed?	No	Yes
Have you had uterine fibroids?	No	Yes
Do you lose urine when you cough or sneeze?	No	Yes
If any yes, when?	_____	

Patient Name: _____ Date: _____

Sex

Do you have decreased sexual desire?	No	Yes
Do you feel like making love less often than your used to?	No	Yes
Is sexual intercourse NOT as pleasurable as it used to be?	No	Yes
Do you have more difficulty in achieving an orgasm?	No	Yes
Have you ever had pain after intercourse?	No	Yes
Is the pain due to vaginal dryness?	No	Yes
Have you ever had pain during intercourse?	No	Yes
If any yes, for how long?	_____	

Pregnancy

How many pregnancies have you had? _____

How many live births have you had? _____

How many miscarriages have you had? _____

How many children do you have? _____

What was the date of you last child's birth? _____

How old were you at your last delivery? _____