

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:

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®, Somnexam®, Nytol®)

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

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): _____

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/Aunt/Uncle |
| 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/Aunt/Uncle |
| 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/Aunt/Uncle |
| 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/Aunt/Uncle |
| 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/Aunt/Uncle |
| 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/Aunt/Uncle |
| 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/Aunt |
| 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/Aunt/Uncle |
| 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/Aunt/Uncle |
| 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/Aunt/Uncle |
| 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/Aunt/Uncle |
| 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/Aunt |
| 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/Uncle |
| 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/Aunt/Uncle |
| 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/Aunt/Uncle |
| 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/Aunt |

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? _____

Thyroid

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

- constipated depressed fatigued intolerant to heat
- intolerant to cold nervous not sleeping well at night palpitations?
- skin dry weight gain 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? _____

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

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? _____

FOR MEN ONLY

Are your breast getting fatty?	No	Yes
Do you have excessive anxiety?	No	Yes
Do you feel less confident and more hesitant?	No	Yes
Do you feel like making love less often than you used too?	No	Yes
Do you feel your sexual performance is poorer than it used to be?	No	Yes
Do you have hot flashes and sweats?	No	Yes
Are you indecisive?	No	Yes
Do you lack sexual desire?	No	Yes
Have you lost attraction towards your partner?	No	Yes
Is sexual intercourse less pleasurable than as it used to be?	No	Yes