NEW PATIENT HEALTH SURVEY

Welcome to our practice. As a new patient, please answer the questions below to the best of your ability.

Date ____________________

Patient Name ____ **Birth Date** ______________________________

Home Phone _____________________________ **Work or Cell Phone** ___________________________ **Email** ____________________________

Address ____ **City** ___________________ **State** __________ **Zip Code** ____________

How did you hear about us? ____

Describe your main complaint(s) ____

____

If your complaint is due to pain, complete the following:

Location _____________________________________ **Severity on a scale of 1** ____ **10**

Quality _____________________________________ **Duration** ____

Time _____________________________________ **What makes it better or worse?** ____________________________________

Do you have any other health concerns? ____

MEDICAL HISTORY: List any other doctors you've seen for this condition ____

Who is your current family physician? _______________________________________ **Specialist?** __________________________________

Date of your last physical exam ____________________ **When did you have your last blood tests?** __________________________________

List any diagnoses or treatments ____

List any surgeries or major illness with date of occurrence ____

Have you had any infectious diseases? ____

Have you been hospitalized for this or any condition? ____

Do you have any allergies? ____________________________ **Have you ever reacted to medications?** ________________________________

MEDICATIONS: List all prescription or over-the-counter drugs you are taking ____

____

NUTRIONAL SUPPLEMENTS: List all vitamin, mineral, and other nutritional or herbal supplements ______________________________

____

LIFE STYLE INFORMATION: Answer the following questions with YES or NO and explain if necessary

__ **Do you exercise? How often?** ________________________________ **What type?** ____

__ **Do you use alcohol? How often?** _____________________________ **What kind?** ____

__ **Do you smoke? How much?** _____________________ **For how long?** ____________________ **When did you quite?** _________________

__ **Do you drink coffee?** ____

__ **Do you drink caffeinated sodas?** ____

__ **Do you follow a specific diet?** ____

__ **Are you concerned about your weight? Are you following a specific diet?** ____

__ **Do you overeat? How is your appetite?** __________________ **Do you have any reactions to foods?** ______________________________

— **Do you crave sweets? Do you have any other food cravings? ______________________________Or aversions?**
____

— **Are you concerned about aging? Do you have a specific concern?**
____

— **Are you concerned about your appearance? Have you used any aesthetic therapies?**
____

— **Are you stressed or anxious?**
____

— **Do you or have you experienced depression? Is there any form of depression or dementia in your family?**
____

— **Do you suffer from insomnia or any other form of sleep abnormality?**
____

— **Are you concerned about memory loss?**
____

— **Do you practice any form of stress reduction such as meditation, tai chi or yoga?**
____

— **Is your relationship fulfilling? _____________________________________ How is your children's health?**
____

— **Do you experience fatigue?**
____

DIETARY INFORMATION: Describe your daily diet ____
____

ADDITIONAL INFORMATION: Describe any other information you feel is important for your doctor to know _______________________
____

BIOMARKER QUESTIONNAIRE

Age _________ Sex________ Height ________ Weight _________ BMI _________

Have you experienced any of the following?

€ Decreasing muscle mass
€ Reduced strength
€ Decreased joint mobility
€ Increased stiffness
€ Reduced capacity for work and exercise
€ Decreased endurance
€ Significant weight loss
€ Increased body fat
€ Increased waist to hip ratio (more fat deposits on the abdomen and waist)
€ Reduced sexual drive and/or performance
€ Muscle mass loss or flabbiness
€ Changes in body temperature
€ Sensitivity to cold or heat
€ Hot flashes
€ Dryer or thinning skin and hair
€ Brown or red spots
€ Spider veins on the skin
€ Slow wound healing
€ Frequent colds or flu
€ Presence of viral infections: Herpes Zoster (shingles), Epstein Barr, HIV, HHV-6, Hepatitis
€ Chronic pain or inflammation
€ Poor sleep

€ Waking up tired
€ Fatigue
€ Longer recovery time needed after exertion
€ Forgetfulness
€ Increasing difficulty concentrating
€ Mood changes
€ Unexplained depression
€ Anxiety
€ Increased anger or irritability
€ Sensitivity to certain foods
€ Craving for sugar
€ Alcohol intolerance

Have you had any of the following tests?

€ Complete Blood Count
€ Chemistry Panel
€ PSA (Prostate Specific Antigen) and prostate exam for men over 40
€ Breast Exam and Mammography for women
€ Pap Smear (for women)
€ Colonoscopy
€ Basal Temperature
€ 3-5 hour Glucose Tolerance Test
€ Fasting insulin
€ Blood Lipids: total Cholesterol, triglycerides, HDL, and LDL
€ Thyroid Studies (TSH, T4)
€ Free T3
€ Homocysteine
€ Blood Pressure
€ Bone Density
€ Treadmill Test
€ Estrogen levels
€ Testosterone
€ Free testosterone
€ IgF-1 (a marker for human growth hormone)
€ DHEA-S
€ Cortisol
€ SHBG (sex hormone binding globulin)

FAMILY HISTORY: Has anyone in your immediate family had any of the following conditions?

❑

€ Heart or coronary arterial disease (congestive heart failure, angina, etc.)
____

€ Atherosclerosis (hardening of the arteries)
____

€ High cholesterol or other form of abnormal lipids
____

€ Heart attack or stroke
____

€ Diabetes or any form of metabolic disease or obesity
____

€ Cancer and list type(s)
____

€ Osteoporosis or any form of bone disease
____

€ Thyroid disease
____

€ List any other diseases in your family
____

FATIGUE QUESTIONNAIRE

Answer the questions below by checking each applicable box if you have ever experience any of the following:

€

- € **Exhausted feelings that are not related to stress or amount of work or exercise.**
- € **Morning tiredness, even after a full night's sleep.**
- € **Depression that does not respond to antidepressants, diet, or exercise.**
- € **Unexplained anxiety and panic attacks.**
- € **Been told that I move as if in slow motion, and take too long to responds to questions.**
- € **A frequently low or hoarse voice (for a woman).**
- € **Mental sluggishness and have difficulty focusing.**
- € **Low sex drive and do not experience significant sexual arousal.**
- € **High cholesterol that has been unresponsive to diet or medications.**
- € **A tendency to feel cold even in warm weather.**
- € **Chronic aches and pains not due to accidents or exercise.**
- € **Carpal tunnel syndrome**
- € **Problems with allergies.**
- € **Difficulty losing weight and keeping it off.**
- € **Very dry skin.**
- € **I have acne or eczema.**
- € **Diabetes**
- € **Rheumatoid arthritis or other autoimmune condition.**
- € **Problem with my periods, including abnormal menstrual bleeding.**
- € **Anemia**
- € **Infertility or a history of frequent miscarriages.**
- € **Significant menopausal symptoms.**
- € **A tendency to have chronic constipation even with a high fiber diet.**
- € **Lots of hair falling out or brittle hair.**
- € **Vitiligo or other unusual changes in skin color.**
- € **Trembling of my hands or stumbling for no reason.**
- € **Have a family history of thyroid disorder**
- € **Have previously been diagnosed with a thyroid disorder**

In case of emergency, notify ________________________________ Phone No. ______________Relationship ___________

I understand that all fees for consultations, examinations, treatments, and supplies are to be paid for as they are received.

PATIENT'S SIGNATURE: ____ Date ______________________