Best Hormone Replacement Clinic
Akron - Cleveland - Dayton, Ohio

PATIENT INFORMATION

Name *(Last, First, M.I.):*		**Today's Date**	
Address *(Street.):*		**Date of Birth**	
(City, State, Zip.):		**Occupation**	
Email		**Employer**	

Phone	H:	M:	W:

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Children ***(Names, Ages)***	

EMERGENCY CONTACT INFO	**Name** *(Last, First, M.I.):*		
Phone	H:	M:	W:
Relationship to Patient			

Primary Care Physician:		**Physician's Phone Number:**	
How did you hear about us?			

MEDICAL HISTORY

**Integrative Medical Healthcare is possible only when the physician has the complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Thank you.*

Please comment about your major health and wellbeing concerns in order of importance to you. It will help if you include to what extent they affect your daily life now.

1.		**Date of Onset:**	
2.		**Date of Onset:**	
3.		**Date of Onset:**	
4.		**Date of Onset:**	

When and where did you last receive medical healthcare?	
For what reason?	

Medications & Supplements

Please list all prescription medications that you are currently taking, the doses and for what conditions:

Please list all natural supplements that you are currently taking, the doses and for what conditions:

Personal Past & Current Medical History		
Please specify diagnosis	Date of Onset	Treatments
Have you undergone a course of antibiotics recently?		

General					
Height:		Weight (lbs):		Weight 1 year ago:	
Maximum Weight (lbs):			When?		

Hospitalizations, Surgery, Imaging			
What hospitalizations, surgeries, X-Rays, CT Scans, EEG, EKG have you had?			
Procedure	Year	Procedure	Year

Daily Routines			
Please describe your daily activities from when you awake until you go to sleep. Include a "typical" meal or types of foods you eat, as well as your exercise, work and other activities.			
MORNING	Time	Activities, Foods, Routines	Variation
Awaken			
Breakfast			
Activities after Breakfast			
MIDDAY	Time	Activities, Foods, Routines	Variation
Lunch			
Activities after Lunch			
EVENING	Time	Activities, Foods, Routines	Variation
Dinner			

Activities after Dinner			
NIGHT	**Time**	**Activities, Foods, Routines**	**Variation**
Activities			
Bed Time			
List other regular activities not included above. These could be exercise, meditation, spiritual practices, etc.			
Water amount in ounces or cups per day:			
Alcohol beverages per week:		Caffeinated beverages per day:	
Dietary restrictions or type of diet:			

Lifestyle & Habits					
For the following, please mark: Y= Condition you have now N= Never Had P= Significant problem of the Past					
Main interests and hobbies?					
What are the major stressors in your life?					
Do you exercise?	☐Y / ☐N	Length of time		Times per week	
Type(s) of exercise?					

Average 6-8 hours of sleep?	☐Y / ☐N	Enjoy your work?	☐Y / ☐N
Sleep well?	☐Y / ☐N	Take vacation	☐Y / ☐N
Awaken rested?	☐Y / ☐N	Spend time outside?	☐Y / ☐N
Time(s) you awaken?		How many hours of TV/week?	
History of abuse?	☐Y / ☐N / ☐P	How many hours of reading/week?	
Any major traumas?	☐Y / ☐N / ☐P	How many hours of computer/week?	
Been treated for drug dependence?	☐Y / ☐N / ☐P	Do you go on diets often?	☐Y / ☐N / ☐P
Use of alcoholic beverages?	☐Y / ☐N / ☐P	Do you drink coffee?	☐Y / ☐N / ☐P
Treated for alcoholism?	☐Y / ☐N / ☐P	Drink black tea?	☐Y / ☐N / ☐P
Smoked previously	☐Y / ☐N / ☐P	Do you drink cola/other sodas	☐Y / ☐N / ☐P
How many years smoking?		Do you eat refined sugar?	☐Y / ☐N / ☐P
Do you have a religious practice?	☐Y / ☐N	If yes, what?	
On a scale of 1-10 (10 being the best), how committed are you to improving your health?			
On a scale of 1-10, how much change are you willing to make at this time for improving your health?			

Childhood Illnesses

Have you had any of the following childhood illnesses? (mark if yes)					
☐ Scarlet Fever	☐ Diphtheria	☐ Rheumatic Fever	☐ Mumps	☐ Measles	☐ German Measles

Have you had any immunizations?	☐Y / ☐N	Did you have any negative reactions?	☐Y / ☐N

Allergies			
Please list if you are hypersensitive or allergic to the following:			
Drugs:			
Foods:			
Environmentals or chemicals:			

Family Medical History					
Please specify: M = mother, F = father, S = sister, B = brother, A = aunt, U = uncle, PGM = paternal grandmother, PGF = paternal grandfather, MGM = maternal grandmother, MGF = maternal grandfather					
Cancer		Diabetes		Epilepsy	
Heart Disease		High Blood Pressure		Stroke	
Anemia		Kidney Disease		Glaucoma	
Allergies		Asthma		Mental Illness	
Arthritis		Tuberculosis		Alzheimer's Disease	

REVIEW OF SYSTEMS			
RESPIRATORY			
☐ Common Colds	☐ Asthma	☐ Wheezing	☐ Difficulty Breathing
☐ Shortness of Breath	☐ Emphysema	☐ Pneumonia	☐ Persistent Cough
☐ Pleurisy	☐ Tuberculosis	☐ Other:	
SKIN			
☐ Eczema	☐ Psoriasis	☐ Hives	☐ Itching
☐ Acne	☐ Boils	☐ Melanoma	☐ Other:
HEAD			
☐ Headaches	☐ Migraines	☐ Head Injury	☐ Jaw / TMJ / Clicks
EYES			
☐ Impaired Vision	☐ Glasses or Contacts	☐ Blurriness	☐ Eye Pain / Strain
☐ Spots in Vision	☐ Color Blindness	☐ Double Vision	☐ Tearing or Dryness
☐ Glaucoma			
EARS			
☐ Impaired Hearing	☐ Earaches	☐ Ringing	☐ Dizziness

NOSE AND SINUSES			
☐ Nose Bleeds	☐ Stuffiness	☐ Hay Fever	☐ Sinus Problems
☐ Loss of Smell			
MOUTH AND THROAT			
☐ Frequent Sore Throat	☐ Copious Saliva	☐ Dry Mouth	☐ Gum Disease / problems
☐ Teeth Grinding	☐ Dental Cavities	☐ Hoarseness	☐ Sore Tongue / Lips
NECK			
☐ Goiter	☐ Lumps	☐ Swollen Glands	☐ Pain or Stiffness
CARDIOVASCULAR			
☐ Anemia	☐ Hearth Disease	☐ High Blood Pressure	☐ Poor Circulation
☐ Palpitations	☐ Stroke	☐ Chest Pain	☐ Heart Murmurs
☐ Rheumatic Fever	☐ Varicose Veins	☐ Irregular Heart Beat	☐ Mitral Valve Prolapse
☐ Angina	☐ Fainting	☐ Swelling in Ankles	☐ Blood Clots
☐ Deep Leg Pain	☐ Cold Hands / Feet	☐ Easy Bleeding or Bruising	
GASTROINTESTINAL			
☐ Nausea / Vomiting	☐ Abdominal Pain	☐ Ulcers	☐ Heartburn
☐ Belching	☐ Passing Gas	☐ Bloating	☐ Changes in Appetite
☐ Epigastric Pain	☐ Gall Bladder Disease	☐ Liver Disease	☐ Hepatitis B or C
☐ Hemorrhoids	☐ Crohn's Disease	☐ Gluten Sensitivity	☐ Irritable Bowel Syndrome
☐ Changes in Thirst	☐ Changes in Appetite		
GENITO-URINARY			
☐ Painful Urination	☐ Frequent Urination	☐ Frequent UTI	☐ Interstitial Cystitis
☐ Heavy Flow	☐ Impaired Urination	☐ Blood in Urine	☐ Urination at Night
☐ Kidney Stones	☐ Kidney Disease		
MUSCULOSKELETAL			
☐ Neck Pain	☐ Shoulder Pain	☐ Arm Pain	☐ Upper Back Pain
☐ Mid-Back Pain	☐ Low Back Pain	☐ Leg Pain	☐ Muscle Spasms / Cramps
☐ Joint Pain	If Joint Pain, where?		
NEUROLOGICAL			
☐ Vertigo / Dizziness	☐ Paralysis	☐ Loss of Balance	☐ Numbness / Tingling
☐ Seizures / Epilepsy	☐ Loss of Memory		
ENDOCRINE			

☐ Hypothyroid	☐ Hashimoto's	☐ Hyperthyroid	☐ Diabetes Type I or Type II
☐ Hypoglycemia	☐ Polycystic Ovarian Syndrome (PCOS)	☐ Metabolic Syndrome	☐ Night Sweats
☐ Feeling Hot or Cold	☐ Other:		
EMOTIONAL			
☐ Mood Swings	☐ Nervousness	☐ Depression	☐ Anxiety
☐ Mental Tension	☐ Eating Disorder	☐ Insomnia	☐ Suicidal
☐ Frustration	☐ Irritability	☐ Anger	☐ Over Thinking
☐ Sadness	☐ Grief	☐ Fear / Fright	
ENERGY & IMMUNITY			
☐ General Fatigue	☐ Awakens Unrested	☐ Fatigue After Meals	☐ Irritable Before Meals
☐ Slow Wound Healing	☐ Chronic Infections	☐ Chronic Fatigue Syndrome	☐ Frequent Colds
☐ Autoimmune Disease	☐ Allergies	☐ Hay Fever	☐ Chronically Swollen Glands
☐ Other:			

MALE REPRODUCTIVE			
☐ Prostate Problems	☐ Penile Discharge	☐ Inguinal Hernias	☐ Venereal Disease
☐ Low Libido	☐ Sexual Difficulties	☐ Impotence	☐ Testicular Pain / Swelling
Sexual Orientation:	Are you sexually active? ☐Y / ☐N		
FEMALE REPRODUCTIVE / BREASTS			
☐ Irregular Menstrual Cycles	☐ Painful Menses	☐ Heavy Menstrual Flow	☐ Bleeding Between Cycles
☐ Clotting	☐ Spotting	☐ Vaginal Discharge	☐ Premenstrual Problems
☐ Endometriosis	☐ Ovarian Cysts	☐ Cervical Dysplasia	☐ Difficulty Conceiving
☐ Menopausal Symptoms	☐ Sexual Difficulties	☐ Low Libido	
☐ Regular Self Breast Exam	☐ Breast Lumps	☐ Breast Tenderness	☐ Nipple Discharge
Sexual Orientation:		Number of male partners in the past 3 years?	

MENSTRUAL / BIRTHING HISTORY					
Age of First Menses:		Are your cycles regular?	☐Y / ☐N / ☐P	**Date of Last Menstrual Period**	
Length of cycle from one cycle to the next (days)?			How many days of bleeding during cycle?		
Type of Birth Control:		Dose:		Length of Use:	
Type of Birth Control(s) used in Past:			Contraceptive Difficulties?		
Date of last PAP exam:		Abnormal PAP exam?	☐Y / ☐N / ☐P	If yes, when?	
Are you pregnant now?	☐Y / ☐N		If yes, how many number of weeks?		

Number of Pregnancies:			Any complications with pregnancy?		
Number of Live Births:		Number of Abortions:		Number of Miscarriages:	

Patient's or Authorized Person's Signature:

Patient Name (please print):	Patient Signature	Date

RESPONSIBLE PARTY: fill out if you are not the patient but are responsible for the bill.			
Responsible Party		**Relationship to Patient**	

Thank you for your time and effort.

We look forward to providing you with the best possible medical care.