

Lifetime Health Personal Health History

Name _____ Date _____

Address _____ City: _____

State: _____ Zip: _____ Occupation: _____

Phone (Home) _____ (Work) _____ (Cell) _____

DOB: _____ Age _____ Referral Source _____

Email: _____ # of Children: _____

Drug Allergies: _____ Other Allergies: _____

Birth Control (describe): _____

Current Meds and Vitamins: _____

Surgeries: (include dates): _____

Height: _____ Weight: _____ Last Blood Pressure Reading _____

Date of BP Reading _____ Current Treating Physician(s): _____

Family History:

- Heart Disease High Blood Pressure Stroke Cancer Glaucoma Diabetes Obesity
 Epilepsy Kidney Disease Thyroid Disease Mental Disorder Osteoporosis

Personal Medical History

- Headache Shortness of Breath Heart Palpitations Heart Murmur Chest Pain
 Dizziness/Fainting Problems with Circulation Allergies/Hay Fever Asthma
 Bronchitis Pneumonia Ulcer GI disorder Lactose intolerance
 Gallbladder disease Prostate disease Bowel Irregularity Incontinence
 Venereal disease Frequent infections Hepatitis Anemia Arthritis
 Osteoporosis Nervousness Joint Pain Depression Gout Scarlet Fever
 Chronic Fever Rheumatic Fever Mumps Measles Rubella
 Polio Diphtheria Tetanus Muscle aches Diabetes Obesity

Women Only

Menstrual Period Y ___ N ___ Age of onset _____ Cramps Y ___ N ___

Regular Y ___ N ___ Irregular Y ___ N ___ **Date of Last Period:** _____

Duration of Period (days) _____ **Bleeding Description:** Light ___ Medium ___ Heavy ___

Moodiness/Depression with Menses Y ___ N ___ Last Pap Smear: _____

Trouble with arousal or desire Y ___ N ___

Vaginal Dryness Y ___ N ___ Last Mammogram: _____

Frequent vaginal infections Y ___ N ___

Losing urine w/ coughing or sneezing Y ___ N ___ Last Chest X-Ray: _____

Have you had a Hysterectomy? Y ___ N ___ Partial ___ Total ___ Date _____

Have you had an ablation? Y ___ N ___ **Tubal Ligation?** Y ___ N ___ Other? _____

Miscarriages Y ___ N ___

Men Only

Prostate problems	Y__ N__
History of Prostate Cancer	Y__ N__
Trouble Urinating	Y__ N__
Decrease in size of urinating stream	Y__ N__
Number of times urinating at night	_____
Trouble with erectile dysfunction	Y__ N__
Trouble with premature ejaculation	Y__ N__
Decreased Sex Drive	Y__ N__

Sleep: Difficulty falling asleep	Y__ N__	Daytime drowsiness	Y__ N__
Snoring	Y__ N__	Early morning awakening	Y__ N__
Wake Up Refreshed	Y__ N__	Sleep Apnea	Y__ N__

Habits

Smoke: Packs daily _____	Coffee: Cups daily: _____
How long? _____	Other caffeine: _____ Diet Sodas _____
Interested in stopping? _____	Alcohol: Type: _____
Drug History? Y__ N__	How many drinks _____ daily _____ weekly

Pace Makers or Any Other Medical Devices: _____

Have you been treated for a mental disorder? Y__ No __ Eating disorder? Y__ N__

If yes, please describe: _____

Have you ever taken Natural Hormones or Synthetic Hormones? Y__ No __

If yes, name the hormones and describe your experience with the hormones:

Have you ever been involved in a Weight Loss Program(s)? Y__ No __

Have you ever taken weight loss medications? Y__ No __

If yes, please describe program/medications: _____

Weight Gain History (mark those that apply)

No problem with weight: _____

My weight concerns started: child __, teen __, adult __, peri/post menopausal __

- **RATE:** rapid weight gain _____ or slow weight gain _____
- **INCITING FACTORS:** stress __, marriage __, divorce __, illness __, accident __, medication _____, birth control _____, hysterectomy _____, tubal _____, ablation _____, depo provera injection __, other _____.

Primary Health Concern(s) /Objective(s): _____

Hormonal Symptoms

Circle any symptoms you may have and mark the severity of any symptoms.

<i>Severity:</i>	<i>Mild</i>	<i>Moderate</i>	<i>Severe</i>
• Poor resistance to stress	_____	_____	_____
• Loose or wrinkled skin	_____	_____	_____
• Pouches under the eyes	_____	_____	_____
• Drooping triceps	_____	_____	_____
• Increasing stomach size	_____	_____	_____
• Poor muscle tone	_____	_____	_____
• Wrinkled hands	_____	_____	_____
• Thinning skin / hair	_____	_____	_____
• Weight Gain / Trouble losing weight	_____	_____	_____
• Can't gain muscle with exercise	_____	_____	_____
• Feel like you are aging.	_____	_____	_____
• Overall decreased sexual desire	_____	_____	_____
• Fatigue / loss of energy	_____	_____	_____
• Loss of ambition	_____	_____	_____
• Poor muscle tone/ lost muscle strength	_____	_____	_____
• Poor stamina	_____	_____	_____
• High cholesterol	_____	_____	_____
• Constipation	_____	_____	_____
• Short term memory loss	_____	_____	_____
• Throat Clearing	_____	_____	_____
• Headaches and migraines	_____	_____	_____
• Dry Skin	_____	_____	_____
• Slow Heartbeat	_____	_____	_____
• High Blood Pressure	_____	_____	_____
• Cold Extremities (hands, feet)	_____	_____	_____
• Chronic Infections	_____	_____	_____
• Low HDL	_____	_____	_____
• Increased Triglycerides	_____	_____	_____
• Loss of outside 1/3 of eyebrow	_____	_____	_____
• Muscle Cramps	_____	_____	_____
• Swelling of hands and feet	_____	_____	_____
• Reliance on coffee/stimulants	_____	_____	_____
• Diabetes	_____	_____	_____
• ADD / ADHD	_____	_____	_____
• Hypothyroidism in family	_____	_____	_____
• Oral Temp below 98.5	_____	_____	_____
• Puffy eyes and face	_____	_____	_____
• Joint Aches and Pains	_____	_____	_____
• Brittle Nails	_____	_____	_____
• Tingling in fingers/feet	_____	_____	_____
• Experiences Stiffness	_____	_____	_____
• Breast Tenderness	_____	_____	_____
• Tired for no reason?	_____	_____	_____
• Trouble getting up in the morning?	_____	_____	_____

<i>Severity:</i>	<i>Mild</i>	<i>Moderate</i>	<i>Severe</i>
• Cravings for sweets	_____	_____	_____
• Shakiness relieved by eating	_____	_____	_____
• Low blood pressure	_____	_____	_____
• Dizziness upon first standing	_____	_____	_____
• Food craving or sensitivities	_____	_____	_____
• Trouble getting up in the morning?	_____	_____	_____
• Feeling run down and stressed?	_____	_____	_____
• Cravings for sweets	_____	_____	_____
• Shakiness relieved by eating	_____	_____	_____
• Low blood pressure	_____	_____	_____
• Vision Changes	_____	_____	_____
• Mind in a fog (fuzzy thinking)	_____	_____	_____

Females Only

Severity:	Mild	Moderate	Severe
• Hot Flashes	_____	_____	_____
• Breast cancer	_____	_____	_____
• Endometrial (uterine) cancer	_____	_____	_____
• Fibrocystic breasts	_____	_____	_____
• Infertility	_____	_____	_____
• Polycystic ovaries	_____	_____	_____
• Uterine cancer	_____	_____	_____
• Fibromyalgia	_____	_____	_____
• Vaginal and/or bladder infections	_____	_____	_____
• Recurrent urinary tract infections	_____	_____	_____

Others (circle if applicable):

Autoimmune disorders such as Lupus erythematosus and Hashimoto's thyroiditis. _____

Sjogren's syndrome (dry mouth). _____

Allergies, including asthma, hives, rashes, sinus congestion. _____

Increased blood clotting (increasing risk of strokes) / any history of blood clots or clotting. (Explain)

Printed Name: _____

Signature: _____

Date: _____