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VITALITY • STRENGTH • LONGEVITY

Personal Health History

PATIENT INFORMATION

Last Name MI	First	Female ( ) Male ( )	Birth Date	Age
Address	Apt#	City	State	Zip
Home Phone	Cell Phone	Work Number		
E-Mail		Marital Status	Employer	
Height	Weight	Goal Weight?		
Emergency Contact	Relationship		Phone	
Physician	Address		Phone	
Who Referred You?	Name			

This section is for the purpose of learning more about your health history. Please read and answer all of the following questions to the best of your knowledge.

Reason for Consultation

What health concerns and symptoms brings you to the clinic?

____

____

____

____

What would you most like to achieve with this health consultation?

____

____

____

Are you currently under the care of a physician/health professional for a medical/health condition?

❍ Yes ❍ No Physicians Name ____

If yes, please list:

____

____

____

____

Patient Name: ______________________________ Date of Birth: ________________

**Please check any medical conditions or health problems that you currently have or have had in the past?

Past Medical History			
Seizures Disorder	❍ yes ❍ no	Heart Disease	❍ yes ❍ no
Recurrent sinus infection	❍ yes ❍ no	Chest Pain	❍ yes ❍ no
Seasonal allergies	❍ yes ❍ no	Irregular Heart Beat	❍ yes ❍ no
Emotional Illness	❍ yes ❍ no	High Blood Pressure	❍ yes ❍ no
Asthma	❍ yes ❍ no	Blood Clotting problem	❍ yes ❍ no
Chronic bronchitis	❍ yes ❍ no	Bleeding disorder	❍ yes ❍ no
Lung/breathing issues	❍ yes ❍ no	Stroke/vascular disease	❍ yes ❍ no
Chronic Indigestion	❍ yes ❍ no	Constipation/diarrhea	❍ yes ❍ no
Stomach Ulcers	❍ yes ❍ no	Hepatitis/Liver disease	❍ yes ❍ no
Intestinal Disease	❍ yes ❍ no	Kidney disease	❍ yes ❍ no
Skin problems/dermatitis	❍ yes ❍ no	Menstrual disorders	❍ yes ❍ no
Back Pain or Sciatica	❍ yes ❍ no	Reproductive problem	❍ yes ❍ no
Herniated Disc	❍ yes ❍ no	Prostate problems	❍ yes ❍ no
Neck pain	❍ yes ❍ no	Tendonitis	❍ yes ❍ no
Muscle or Joint Pain	❍ yes ❍ no	Chronic pain problems	❍ yes ❍ no
Carpal Tunnel Syndrome	❍ yes ❍ no	Shoulder problems	❍ yes ❍ no
Fibromyalgia	❍ yes ❍ no	Osteoarthritis	❍ yes ❍ no
Diabetes	❍ yes ❍ no	Rheumatoid Arthritis	❍ yes ❍ no
Thyroid disease	❍ yes ❍ no	Artificial joint/implant	❍ yes ❍ no
Osteoporosis/Osteopenia	❍ yes ❍ no	Cancer	❍ yes ❍ no
Psoriasis or eczema	❍ yes ❍ no		

List any additional health problems not listed above:

____

____

____

____

____

____

List any surgeries/operations you have had and when:

____

____

____

Patient Name: ______________________________ Date of Birth: ________________

List any prescribed medications you are currently taking (or have taken in the recent past)

Medication Name	Date Started	Date Stopped	Dosage (# daily)

(If any additional medications please attach a separate page with the above info)

Nutritional supplements, vitamins, herbs, homeopathic remedies taken:

____

____

____

____

Have you ever used Hormone Replacement Therapy or Anabolic Steroids? ❍ yes ❍ no

Medication Allergies:

____

____

Environmental/Food Allergies:

____

____

Preventive Tests:	Date of last test	Results (if known)
Cholesterol	________________	________________
Bone density	________________	________________
Colonoscopy	________________	________________
Exercise stress test	________________	________________

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Patient Name: ______________________________ Date of Birth: ________________

Family History (Write the relationship of the relative(s) with the disease on the adjacent lines)

Heart Disease ❍ yes ❍ no ______________________________

High Blood Pressure ❍ yes ❍ no ______________________________

Diabetes ❍ yes ❍ no ______________________________

Arthritis ❍ yes ❍ no ______________________________

Skin disorders ❍ yes ❍ no ______________________________

Breast Cancer ❍ yes ❍ no ______________________________

Uterine/Ovarian Cancer ❍ yes ❍ no ______________________________

Prostate Cancer ❍ yes ❍ no ______________________________

Colon Cancer ❍ yes ❍ no ______________________________

Other Cancer ❍ yes ❍ no ______________________________

List any other disease/condition in the family and relationship

____

____

____

WOMEN ONLY

ARE YOU PREGNANT? ❍ yes ❍ no **First day** of last menstrual cycle ________________

Date of last pap/pelvic/breast exam ________________ Results: ❍ normal ❍ abnormal

Date of last mammogram ____________________ Results: ❍ normal ❍ abnormal

Do you perform monthly self-breast exams? ❍ yes ❍ no

Are you currently taking or have you in the past taken hormones or oral contraceptives? ❍ yes ❍ no

If yes, please list all hormones and oral contraceptives you have taken and when

____

____

____

Patient Name: ____________________________________ Date of Birth: __________________

Have you ever had any problems or concerns about taking hormone replacement therapy? ❍ yes ❍ no

If yes list problems. ____

How many pregnancies have you had? _______ How many children? _________

Have you had a hysterectomy? ❍ yes ❍ no

If yes, were your ovaries removed? ❍ yes ❍ no

Has your abdominal girth and weight been increasing? ❍ yes ❍ no

Have you had any menstrual irregularities? ❍ yes ❍ no

(if yes explain)

____

____

____

MEN ONLY

Date of last prostate exam: _________________

Are you concerned with loss of muscle mass, tone, or strength? ❍ yes ❍ no

Have you had problems with urination (decreased stream, frequent night urination) ❍ yes ❍ no

Do you perform periodic testicular self-examination? ❍ yes ❍ no

Has your abdominal girth and weight been increasing? ❍ yes ❍ no

Social History and Personal Health Habits

General (Check all that apply)

My health is: ❍ excellent ❍ good ❍ fair ❍ poor.

My physical fitness is: ❍ excellent ❍ good ❍ fair ❍ poor

Stress level:

❍ I am often sad and blue ❍ I have difficulty dealing with stress

❍ I am under a lot of stress ❍ I am fatigued all the time

❍ I practice meditation/relaxation techniques

Dietary Habits

I commonly consume: ❍ Coffee ❍ Regular soft drinks

❍ Candy/chocolate ❍ Chips/crackers ❍ I do not eat dairy/cheese

❍ No special diet habits ❍ Minimizes Carbs ❍ I try to eat a healthy diet

❍ Avoids red meat ❍ Minimizes fat ❍Vegetarian

❍ Diet soda ❍ Emphasize fruits, grains, vegetables

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Patient Name: ______________________________ Date of Birth: ________________

Exercise Habits

- ❍ No special exercise habits
- ❍ I routinely exercise ____hr(s) ____X/week
- ❍ Lift weights
- ❍ Aerobic exercise (jog/walk/treadmill)
- ❍ Swim
- ❍ Stretch/Yoga/Tai Chi/Chi Gong

Other______________________________

Tobacco Use

- ❍ I never smoked cigarettes or chewed tobacco
- ❍ I smoke ______ packs of cigarettes per day.
- ❍ I have smoked for _____years
- ❍ I quit smoking in _______(mo/year).
- ❍ I smoked ______packs/day for _____ years
- ❍ I smoke cigars/pipe
- ❍ I use/used recreational drugs When?____________

What?______________________________

Alcohol Use

- ❍ I never drink alcohol
- ❍ I drink occasionally or socially
- ❍ I regularly drink:
- ❍ 1-2 drinks/day
- ❍ more than 2 drinks/day
- ❍ more than 4 drinks/day

Hobbies/Sports/Recreation

List routine hobbies/sports/recreational activities

____

____

EnVoque MD Consultation Terms

1. I understand that today's consultation is used to determine whether or not I am a candidate for care.
2. I understand that the consultation process does not establish me as a patient under EnVoque MD's care and there is no doctor-patient relationship or obligation.
3. I am aware that after the consultation, I may not be accepted as a patient.
4. I understand that your EnVoque MD Doctor is not able to and does not accept every case.
5. Please fill out all paperwork *completely* to the best of your knowledge.
6. It is necessary that you are under the care of a primary care physician.

I have read, understand and accept the terms of this initial consultation. **I agree that the statements above are true and accurate and I have disclosed all health issues to the best of my knowledge**.

______________________________________ ____________________

Patient Signature Date

A 24 hour notice of cancellation is required. If your cancellation is less than 24 hours or you do not show for your appointment a rescheduling fee will apply before for your next appointment. This is for the consideration of our patients that are waiting for a sooner appointment and allows us the necessary time to contact them with the sooner appointment availability. We thank you for understanding regarding this policy that has proven to be very successful in meeting our patient's medical needs.

Patient Name: ____ Date of Birth: ____________________

Consult/Practitioner comments on above: