

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
 Epilepsy Kidney Disease Thyroid Disease Mental Disorder Osteoporosis

Women Only

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

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

Duration (days) _____

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? _____

Men Only

Prostate problems 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 ___

Female Hormones Form

Wake Up Refreshed Y__ N__ Sleep Apnea Y__ N__

Habits

Smoke: Packs daily _____
How long? _____
Interested in stopping? ____ **Coffee:** Cups daily: _____
Other caffeine: _____ Diet Sodas ____
Alcohol: Type: _____
How many drinks _____ daily ____ weekly

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

Pace Makers or Any Other Medical Devices: _____

Do you have sugar cravings? Y ____ N ____ . Carbohydrate Cravings? Y ____ No ____

If yes, please describe: _____

Have you ever been treated for a mental disorder? Y __ No ____

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: _____

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

Signature: _____

Date: _____

Females

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

Severity: Mild Moderate Severe
Female Hormones Form 2

• 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	_____	_____	_____
• Irritability/Mood Swings	_____	_____	_____
• Irregular Periods	_____	_____	_____
• Severity:	Mild	Moderate	Severe
• Heavy Menstrual Bleeding	_____	_____	_____
• Water Retention	_____	_____	_____
• Hot Flashes	_____	_____	_____

- Breast cancer _____
- Breast tenderness _____
- Endometrial (uterine) cancer _____
- Fibrocystic breasts _____
- Fluid retention _____
- Hypoglycemia _____
- Infertility _____
- Polycystic ovaries _____
- Uterine cancer _____
- Fybromyalgia _____
- Tired for no reason? _____
- Trouble getting up in the morning? _____
- Feeling run down and stressed? _____
- Cravings for sweets _____
- Shakiness relieved by eating _____
- Low blood pressure _____
- Dizziness upon first standing _____
- Food craving or sensitivities _____
- Vaginal and/or bladder infections _____
- Recurrent urinary tract infections _____
- Vision Changes _____
- Mind in a fog (fuzzy thinking) _____

Others (circle if applicable):

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

Sjoogren'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: _____