Patient Information

*Name: *DOB: *Gender: Male *Race:

*Address:

*City: *State: *ZIP:

*Phone 1: Mobile 1: Email:

Phone 2: Mobile 2: Fax:

Soc. Sec.: Status: Spouse/Partner:

Contact Preference(s): Best time(s) to contact you:

Where did you hear about us?

SECONDARY RESIDENCE

Address:

City: State: ZIP:

Phone: Mobile: Email:

WORK

Employer: Occupation:

Address:

City: State: ZIP:

Phone: Mobile: Email:

EMERGENCY CONTACT

Name: Relationship:

Address:

City: State: ZIP:

Phone: Mobile: Email:

Your Primary Care Provider: Phone: Fax:

☐ Complete insurance section only if box is checked

INSURANCE

Person responsible for bill: DOB: Gender:

Patient's relationship to person responsible for bill:

Address:

City: State: ZIP:

Phone: Fax: Email:

Soc. Sec.: Is patient covered by insurance?: ☐ Yes ☐ No

Primary Insurance: Secondary Insurance:

Group no. Policy no.: Co-payment: $

CONSENT FOR MEDICAL SERVICES

PATIENT and the PRACTICE hereby enter into this agreement for provision of medical services specified herein (SERVICES). Wherefore, in exchange for consideration, the receipt and sufficiency of which the parties hereby acknowledge the PATIENT and PRACTICE agree as follows:

1. **The PATIENT acknowledges and agrees that this agreement has been entered into before the PRACTICE has provided the SERVICES specified herein to the PATIENT.**
2. **The PATIENT acknowledges and agrees that this agreement has not been entered into at a time when the PATIENT is facing an emergency or an urgent health care situation.**
3. **The PATIENT acknowledges reading and receiving a copy of the Notice of Privacy Practices, and by signing this agreement, the PATIENT authorizes the PRACTICE and its representatives to use and share PATIENT health information as described in the Notices of Privacy Practices.**
4. **The PATIENT agrees to let PRACTICE, its agents, employees, and physician(s) provide medical care services. The SERVICES provided to the PATIENT may include, but are not limited to:**
    a. **Evaluation of patient medical history and lifestyle behaviors**
    b. **Physical examination**
    c. **Blood, urine, fecal, and/or saliva tests**
    d. **Diagnostic testing, bioelectrical and/or imaging tests**
    e. **Medical recommendations and management regarding my health issues and disease prevention, e.g., nutrition, nutritional supplementation and/or replacement, physical activity, functional performance, and exercise, lifestyle, environment, and behavior, stress response management, hormone replacement therapy**
    f. **Medication prescription management for those medications prescribed by the PRACTICE**
    g. **Procedures may include, but are not limited to: Injections, intravenous infusion therapy, aesthetic procedures**

PATIENT agrees that PRACTICE has not made any claims or statements about results or cures.

PATIENT acknowledges the right to revoke this consent at any time except to the extent PRACTICE has already taken action in reliance on it. If PATIENT does not revoke it, this Consent will continue indefinitely.

By signing this agreement, the PATIENT acknowledges that PATIENT has read and fully understands the information contained in this agreement. PATIENT agrees that everything in this Consent applies to current and future health care services provided by PRACTICE.

PATIENT SIGNATURE: **Date:**

(Signature required)

Medical History

INSTRUCTIONS: Complete each section as completely, and candidly, as possible. Some sections have specific instructions. Items marked with an (*) are required, if applicable.

☐ CHECK IF NONE

MY PRIMARY HEALTH CONCERNS / GOALS

☐ CHECK IF NONE

CURRENT MEDICAL PROBLEMS

☐ CHECK IF NONE

ALLERGIES

☐ CHECK IF NONE

MEDICATION SENSITIVITIES / REACTIONS

☐ CHECK IF NONE

CURRENT MEDICATIONS (Prescription & non-prescription - name/dose/reason for taking)

☐ Thyroid:	☐ Cholesterol Med:	
☐ Testosterone:	☐ Regular or frequent use of corticosteroids	
☐ Blood Sugar Med:	☐ Human Growth Hormone:	
☐ Blood Pressure Med:		

☐ CHECK IF NONE

CURRENT SUPPLEMENTS (name/dose/reason for taking)

☐ DHEA		

☐ CHECK IF NONE

IMMUNIZATIONS

Immunization	Yr. of Last	Immunization	Yr. of Last	Immunization	Yr. of Last	Immunization	Yr. of Last
☐ Hepatitis A		☐ Influenza (Flu)		☐ Polio		☐ Varicella	
☐ Hepatitis B		☐ Meningococcal		☐ Pneumonia		☐ Zoster	
☐ Human Papilloma Virus		☐ MMR		☐ Tetanus/Td		☐ Haemophilus Influenza b	

☐ CHECK IF NONE

SCREENING TESTS

Screen	Year of Last	Results?	Screen	Year of Last	Results?
☐ Dental Exam			☐ Bone Density (DXA)		Total hip T-Score: ☐ Unknown
☐ Eye Exam			☐ Lipids		Cholest: LDL: HDL: Trigl:
☐ Skin Exam			☐ Fasting Blood Sugar		Blood level:
☐ Blood Pressure		Systolic: Diastolic:	☐ Vitamin D level		Blood level:
☐ Colonoscopy			☐ PSA (Prostate Test)		Blood level: ☐ Never had the test
☐ Carotid Ultrasound			☐ Thyroid		TSH: Free T3: Free T4:

☐ CHECK IF NONE

HOSPITAL ADMISSIONS / SURGERIES (Not including pregnancies)

Illness/Procedure	Year	Illness/Procedure	Year	Illness/Procedure	Year
☐ Prostatectomy		☐		☐	
☐ Heart surgery		☐		☐	
☐ Chest irradiation prior to age 30		☐		☐	

☐ CHECK IF NONE

FAMILY HISTORY

INSTRUCTIONS: check boxes if a **first-degree** blood relative (your parent, sibling or child) has suffered any of the following

☐ Alcoholism
☐ Alzheimer's
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Bleeds easily
☐ Colon Cancer
☐ Crohn' Disease
☐ Diabetes*
☐ Epilepsy
☐ Familial hyperlipidemia
☐ Glaucoma
☐ Hay fever
☐ Heart disease
☐ Hepatitis
☐ Hypertension
☐ Lipid disorder
☐ Melanoma
☐ Mental illness
☐ Osteoporosis
☐ Prostate Cancer
☐ Skin cancer
☐ Stroke
☐ Thyroid disease

*If Diabetes: ☐ Parent OR Sibling; ☐ Parent AND Sibling

Additional family history details – list which relative(s) and brief explanation if needed):

System Review

EYES

☐ CHECK IF NONE

- ☐ Recent visual changes
- ☐ Wear glasses/contacts
- ☐ Eye pain
- ☐ Floaters
- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Double vision
- ☐ Blind spots
- ☐ Feeling like a curtain pulls down over vision
- ☐ Loss of central vision

ENT (ears, nose, mouth, throat)

☐ CHECK IF NONE

- ☐ Ear pain
- ☐ Frequent ear infections
- ☐ Ringing in ears (tinnitus)
- ☐ Stuffy ears
- ☐ Recent hearing loss
- ☐ Vertigo
- ☐ Chronic runny nose
- ☐ Frequent sinus pain
- ☐ Sinus infections - recurrent
- ☐ Frequent nose bleeds (epistaxis)
- ☐ Loss of sense of smell
- ☐ Dental problems
- ☐ False teeth
- ☐ Bleeding gums
- ☐ Mouth infections
- ☐ Floss teeth: ____ times per week
- ☐ Gingivitis
- ☐ Periodontal disease
- ☐ Cavities
- ☐ Grinding of teeth
- ☐ Temporomandibular syndrome
- ☐ Sore throats - frequent
- ☐ Chronic hoarseness

CARDIOVASCULAR

☐ CHECK IF NONE

- ☐ Hyperlipidemia (lipid disorder)
- ☐ Heart palpitations
- ☐ Rapid heartbeat
- ☐ Irregular pulse
- ☐ Heart murmur
- ☐ Faintness
- ☐ High blood pressure: (☐ Treated, ☐ Untreated) **&** ☐ Controlled, ☐ Uncontrolled**)**
- ☐ Edema – swollen ankles/feet/lower legs
- ☐ Leg pain when walking (claudication)
- ☐ Varicose veins/phlebitis
- ☐ Cold numb feet
- ☐ Shortness of breath when lying down
- ☐ Shortness of breath with mild exertion
- ☐ Chest pain (angina)
- ☐ Loss of consciousness
- ☐ Heart failure (CHF)
- ☐ Myocardial infarction (heart attack)
- ☐ Rheumatic fever
- ☐ Exercise intolerance
- ☐ Dizziness

RESPIRATORY

☐ CHECK IF NONE

- ☐ Cough - chronic
- ☐ Frequent wheezing
- ☐ Emphysema
- ☐ Use C-pap for sleep apnea
- ☐ Coughing up blood (Hemoptysis)
- ☐ Pleurisy
- ☐ Frequent exposure to: harsh chemicals, metals (lead, mercury, etc.), pesticides, herbicides, asbestos, parrots, chickens, dusty environments

GASTROINTESTINAL

☐ CHECK IF NONE

- ☐ Unexplained changes in bowel habits
- ☐ Bowel movements: ____ every ____
- ☐ Constipation – frequent
- ☐ Diarrhea - frequent
- ☐ Unexplained weight ☐ gain ☐ loss: ____ lb.
- ☐ Feeling full quickly
- ☐ Loss of appetite - recent
- ☐ Abdominal pain - chronic
- ☐ Heartburn/indigestion
- ☐ Cramping
- ☐ Inability to pass gas
- ☐ Peptic ulcer
- ☐ Use of laxative or antacids
- ☐ Use of antacids
- ☐ Nausea/vomiting - persistent
- ☐ Pain or difficulty swallowing (solids vs liquids)
- ☐ Vegetarian/vegan
- ☐ Hemorrhoids
- ☐ Hernia – type: ____
- ☐ Colon polyps
- ☐ Diverticulosis
- ☐ Irritable bowel syndrome
- ☐ Crohn's disease/Colitis
- ☐ Gall bladder trouble
- ☐ Liver disease
- ☐ Jaundice/hepatitis
- ☐ Vomiting blood (hematemesis)
- ☐ Bright red blood per rectum (hematochezia)
- ☐ Foul smelling dark black tarry stools (melaena)
- ☐ Colon cancer
- ☐ Asplenia – functional or loss of spleen
- ☐ Anorexia

MUSCULOSKELETAL

☐ CHECK IF NONE

- ☐ Pain: where? ____
- ☐ Joint swelling
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Osteopenia/osteoporosis
- ☐ Non-traumatic fractures; ☐ after age 50?
- ☐ Lost height (in.): ____
- ☐ Muscle flabbiness
- ☐ Decrease in muscular strength
- ☐ Decreased range of motion: ____
- ☐ Back pain - recurrent
- ☐ Stiffness: ☐ morning ☐ day long
- ☐ Joint pain: ____
- ☐ Gout
- ☐ Muscle twitches
- ☐ Leg discomfort

Do you usually need help getting up from a chair?: ☐ Yes ☐ No

INTEGUMENTARY

☐ CHECK IF NONE

- ☐ Excessive dry skin
- ☐ Unusually warm, moist skin
- ☐ Oily skin
- ☐ Thinning skin
- ☐ Acceleration in skin wrinkling
- ☐ Acne
- ☐ Rashes
- ☐ Frequent itches
- ☐ Hives
- ☐ Eczema
- ☐ Psoriasis
- ☐ Skin nodules:
- ☐ Skin tumors: ____
- ☐ Changes in moles (size, shape, color)
- ☐ Previous melanoma
- ☐ Previous basal cell carcinoma
- ☐ Previous squamous cell carcinoma
- ☐ Dark, velvety, thick skin patches: skin folds/creases
- ☐ Incisions/scars: ____
- ☐ Dry, brittle skin

HEMATOLOGIC/LYMPHATIC

☐ CHECK IF NONE

- ☐ Anemia
- ☐ Use of anticoagulant & antiplatelet drugs
- ☐ Prolonged or excessive bleeding after dental extraction / injury
- ☐ Bruise easily
- ☐ Sickle cell disease
- ☐ Purpura: Hemorrhages in the skin and mucous membranes that result in the appearance of purplish spots or patches
- ☐ History of a receiving a blood transfusion
- ☐ History of being refused for blood donation
- ☐ Petechia: small red or purple spot on the skin or conjunctiva, caused by a minor bleed from broken capillary blood vessels

ALLERGIC/IMMUNOLOGIC

☐ CHECK IF NONE

- ☐ Hay fever
- ☐ Runny nose or itchy/teary eyes
- ☐ Allergy reaction (rash/itch) to foods, animals, etc.
- ☐ Anaphylaxis: to anything (e.g. bee sting, nuts)
- ☐ Asthma ☐ Current ☐ Past
- ☐ Unusual sneezing
- ☐ Swollen/painful glands (groin, arm pits or neck)
- ☐ Chicken pox
- ☐ Measles
- ☐ Mumps
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Rubella (German measles)
- ☐ Shingles

System Review

NEUROLOGICAL

☐ CHECK IF NONE

- ☐ Changes in sight
- ☐ Changes in taste
- ☐ Changes in smell
- ☐ Changes in touch
- ☐ Changes in hearing
- ☐ Change in memory
- ☐ Speech problems
- ☐ Headaches - frequent
- ☐ Migraines
- ☐ Numbness/tingling sensations
- ☐ Tremor/hands shaking
- ☐ Limb weakness
- ☐ Poor balance
- ☐ Fainting spells
- ☐ Seizures
- ☐ Sphincter disturbance
- ☐ Cognitive symptoms
- ☐ History of stroke

PSYCHIATRIC

☐ CHECK IF NONE

- ☐ Panic attacks
- ☐ Nightmares
- ☐ Difficulty concentrating
- ☐ Work and/or school performance problems
- ☐ Obsessions
- ☐ Body image problems
- ☐ Phobias
- ☐ Paranoia
- ☐ Hallucinations
- ☐ Periods of euphoria, delusions, &/or overactivity
- ☐ Episodic changes in personality
- ☐ Sexual or financial binging
- ☐ Lack of energy
- ☐ Decline in your feeling of general well-being
- ☐ Lack of self-confidence
- ☐ In the past month, have you often been bothered by feeling down, depressed, or hopeless?
- ☐ In the past month, have you often been bothered by having little interest in activities or reduced ability to find pleasure in normally enjoyable experiences?

ENDOCRINE / METABOLIC

☐ CHECK IF NONE

- ☐ Hypothyroid
- ☐ Hashimoto's thyroiditis
- ☐ Goiter
- ☐ Thyroid cancer
- ☐ Hyperthyroid
- ☐ Hyperparathyroid disease
- ☐ Diabetes – ☐ Type I ☐ Type II
- ☐ Polydipsia – excessive thirst
- ☐ Polyuria – excessive urination
- ☐ Polyphagia - excessive hunger & eating
- ☐ Food cravings
- ☐ Weight loss despite increased appetite
- ☐ Hypoglycemia - Low blood sugar symptoms
- ☐ Blood pressure drops when getting up
- ☐ Metabolic syndrome
- Libido (sexual desire) ☐ Low ☐ Average ☐ High
- ☐ Decreased ability for sexual arousal
- ☐ Harder to reach climax
- ☐ Hypogonadism
- ☐ Infertility
- ☐ Fatigue daily
- ☐ Sensitive to temperature swings
- ☐ Heat intolerance
- ☐ Sensitivity to cold
- ☐ Increased body fat (esp. around the waist)
- ☐ Exophthalmos – bulging eyes
- ☐ Hair – very dry ☐ Excessive body hair
- ☐ Scalp hair loss - ☐ Recent ☐ Progressive
- ☐ Hair loss from pubic, armpit, body
- ☐ Sparse eyebrows, especially the outer ends
- ☐ Low body temperature
- ☐ Excessive sweating
- ☐ Darkening of skin in non-sun exposed places
- ☐ Recent increase in mood swings
- ☐ Irritability
- ☐ Aggressiveness

URINARY

☐ CHECK IF NONE

- ☐ Urinary frequency
- ☐ Urgency to urinate
- ☐ Difficulty starting stream – hesitancy
- ☐ Decreased force of stream
- ☐ Urine leakage with exercise/straining/cough
- ☐ Incontinence of urine
- ☐ Painful urination – dysuria
- ☐ Nocturia: up to urinate ______ times per night
- ☐ Blood in urine – hematuria
- ☐ Frequent/recurrent urinary infections
- ☐ Kidney/bladder stones
- ☐ Kidney disease

GENITAL / REPRODUCTIVE

Satisfied with frequency of sexual activity: ☐ Yes ☐ No Satisfied with orgasm frequency: ☐ Yes ☐ No

Sexual activity (check all that apply): Current: ☐ Opposite sex, ☐ Same sex, ☐ Single Partner, ☐ Multiple partners (# in past year: ______)

Past: ☐ Opposite sex, ☐ Same sex, ☐ Single Partner, ☐ Multiple partners

☐ CHECK IF NONE

- ☐ Decrease in the number of morning erections
- ☐ Decreased ability to obtain/maintain erection
- ☐ Shrunken testes
- ☐ Decrease in beard growth
- ☐ Night sweats
- ☐ Swollen breasts
- ☐ Enlarged prostate
- ☐ Prostate cancer
- ☐ Orchitis or other testicular problem
- ☐ Adult mumps
- ☐ Feelings that you have passed your peak
- ☐ Low sperm count

Select frequency of symptoms you've had in the past month	Not at All	< 1 Time	< Half the Time	Half the Time	> Half the Time	Almost Always
Had sensation of not emptying bladder completely after urinating?	☐	☐	☐	☐	☐	☐
Had to urinate again less than 2 hours after urinating?	☐	☐	☐	☐	☐	☐
Stopped and started urinating several times?	☐	☐	☐	☐	☐	☐
Found it difficult to postpone urination?	☐	☐	☐	☐	☐	☐
Had a weak urinary stream?	☐	☐	☐	☐	☐	☐
Had to push or strain to begin urinating?	☐	☐	☐	☐	☐	☐
Typically up to urinate from bedtime to getting up?	☐	☐	☐	☐	☐	☐

OTHER

INSTRUCTIONS: enter a rating for each statement below that applies to you

Blank = Never/Rarely; 1 = Occasionally/Slightly; 2 = Moderate Intensity or Frequency; 3 = Intense/Severe or Frequent

- ☐ I have experienced long periods of stress that affect my well-being
- ☐ I have had 1 or more severely stressful events that have affected my well-being
- ☐ I have driven myself to exhaustion
- ☐ I overwork with little play or relaxation for extended periods
- ☐ I have had extended, severe or recurring respiratory infections
- ☐ I have taken long term or intense steroid therapy (corticosteroids)
- ☐ I tend to gain weight, especially around the middle (spare tire)
- ☐ I have a history of alcoholism and/or drug abuse
- ☐ I have environmental sensitivities
- ☐ I have diabetes (type II, adult onset, NIDDM)
- ☐ I suffer from post-traumatic distress syndrome
- ☐ I suffer from anorexia
- ☐ I often do my best work late at night (or very early in the morning)
- ☐ If I don't go to bed by 11 pm, I get a second burst of energy around 11 pm, often lasting until 1-2 am
- ☐ I get coughs/colds that stay around for several weeks
- ☐ I get frequent or recurring respiratory infections (bronchitis, pneumonia, etc.)
- ☐ I get asthma, colds & other respiratory involvement 2 or more times per yr.
- ☐ I frequently get rashes, dermatitis, or other skin conditions
- ☐ I have rheumatoid arthritis
- ☐ I have allergies to several things in the environment
- ☐ I have multiple chemical sensitivities
- ☐ I have chronic fatigue syndrome
- ☐ I get muscle pain in my upper back/lower neck for no apparent reason
- ☐ I get pain in the muscles on the sides of my neck

System Review

☐ I have one or more other chronic illnesses or diseases
☐ My ability to handle stress and pressure has decreased
☐ I am less productive at work
☐ don't think as clearly as I used to
☐ My thinking is confused when hurried or under pressure
☐ I tend to avoid emotional situations
☐ I tend to shake or am nervous when under pressure
☐ I suffer from nervous stomach indigestion when tense
☐ I have many unexplained fears/anxieties
☐ My sex drive is noticeably less than it used to be
☐ I get lightheaded when rising rapidly from a sitting or lying position
☐ I have feelings of graying out or blacking out
☐ I feel unwell much of the time
☐ I notice that my ankles are sometimes swollen – worse in the evening
☐ I usually need to lie down or rest after times of psychological or emotional pressure/stress
☐ My muscles sometimes feel weaker than they should
☐ My hands and legs get restless –meaningless body movements
☐ I have increased frequency/severity of allergic reactions
☐ Small irregular dark brown spots have appeared on my forehead, face, neck & shoulders
☐ When I scratch my skin, a white line remains for a minute or more
☐ I have unexplained and frequent headaches
☐ I am frequently cold
☐ I become hungry, confused, shaky or somewhat paralyzed under stress
☐ I have lost weight without reason while feeling very tired and listless
☐ I have feelings of hopelessness or despair
☐ I have decreased tolerance. People irritate me more
☐ The lymph nodes (glands) in my neck are frequently swollen
☐ I often force myself to keep going. Everything seems like a chore
☐ I am easily fatigued
☐ Difficulty getting up in the morning (don't really wake up til about 10 am)
☐ I suddenly run out of energy
☐ I usually feel much better and fully awake after the noon meal
☐ I often have an afternoon low between 3 – 5 pm
☐ I get low energy, moody or foggy if I do not eat regularly
☐ I usually feel my best after 6 pm
☐ I am often tired at 9-10 pm, but resist going to bed
☐ I like to sleep late in the morning
☐ My best, most refreshing sleep often comes between 7-9 am
☐ I often feel better if I lie down

☐ I have insomnia or difficulty sleeping
☐ I have fibromyalgia
☐ I suffer from asthma
☐ I suffer from hay fever
☐ I suffer from nervous breakdowns
☐ My allergies are becoming worse (more severe, frequent or diverse)
☐ The fat pads on palms of my hands and/or tips of my fingers are often red
☐ Back tenderness near my spine at the bottom of my rib cage when pressed
☐ I bruise more easily than I used to
☐ I need coffee or some other stimulant to get going in the morning
☐ I get swelling under my eyes upon rising that goes away after a couple hrs.
☐ I often crave food high in fat and feel better with high fat foods
☐ I use high fat foods to drive myself
☐ I often use high fat foods & caffeine containing drinks (coffee, colas, chocolate) to drive myself
☐ I often crave salt and/or foods high in salt. I like salty foods
☐ I feel worse after high potassium foods (e.g. bananas, figs, raw potatoes), esp. If eaten in the morning
☐ I crave high protein foods (meats, cheeses)
☐ I crave sweet foods (pies, cakes, pastries, doughnuts, dried fruits, candies or desserts)
☐ I feel worse if I miss or skip a meal
☐ I have constant stress in my life or work
☐ My dietary habits tend to be sporadic and unplanned
☐ My relationships at work and/or home are unhappy
☐ I eat lots of fruit
☐ My life contains insufficient enjoyable activities
☐ I have little control over how i spend my time
☐ I restrict my salt intake
☐ I have gum and/or tooth infections or abscesses
☐ I have meals at irregular times
☐ I feel better almost right away once a stressful situation is resolved
☐ Regular meals decrease the severity of my symptoms
☐ I often feel better after spending a night out with friends
☐ Other relieving factors:
☐ I am chronically fatigued; a tiredness that is not usually relieved by sleep
☐ I sometimes feel weak all over
☐ I have decreased tolerance for cold
☐ I have times of nausea and vomiting for no apparent reason
☐ I have low blood pressure
☐ I do not exercise regularly

Check each of the following descriptions that apply to you

☐ Light colored patches on skin where it has lost its usual color?
☐ Fainting spells?
☐ Increased darkening around bony areas, at skin folds, scars and in joint creases?
☐ Areas inside lips/mouth that have become bluish-black color
☐ Frequent unexplained diarrhea?
☐ Become dehydrated easily?

Social History / Lifestyle

☐ Alcohol drinks:# ____ per ☐ day, ☐ wk, ☐ mo;
☐ Gotten drunk in the past month
☐ Felt the need to stop drinking
☐ High caffeine intake
☐ Tattoos

☐ Use recreational drugs: ☐ injectable
Sun exposure: ☐ Limited ☐ often ☐ Daily
Smoking: ☐ Current: #/day: ____ x ____ yrs.
☐ Never ☐ Past – yr. quit: ____

☐ AIDS/HIV
☐ Sexually transmitted disease(s):
Abuse: ☐ Physical ☐ Sexual ☐ Emotional
☐ Current ☐ Past

Height and Weight

Your *HEIGHT (in.): ____ Your *WEIGHT (lb.): ____ Optional: Your WAIST CIRCUMERENCE (in.): ____

Provider: ☐