Medical Age Management

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Patient Information

Name	Date of Birth: Age:	Gender(circle): M F
	Email	

Address: City: State: Zip:	Home Phone Mobile Phone

Can we leave a message at one of the above numbers? Y/ N

If No, where should we leave messages to confirm appointments & returns calls:

Marital Status (circle): Single Married Seperated/Divorced Widowed In committed Relationship

With whom do you currently live with? (circle): Spouse Partner Children Parents Roommates Alone

Emergency Contact:

Name: _____ Relationship to you: _____ Phone: _____

Occupation: _____

How did you find us?

___Doctor Referral ___Patient Referral ___Web search ___Friend/Family member

If you were referred, please let us know by whom:

Do you have health insurance? Y/N

If Yes, HMO or PPO? Who is your insurance carrier?

Group# Policy #

Please list other heath care providers you are currently working with:

Name	Specialty	Contact Info
1.		
2.		
3.		
4.		

Date of last physical exam?	Date of most recent blood work?

Medical Age Management Financial Policy:

Medical Age Management is a cash-based practice that accepts cash, check or credit card payment. Payment is required on the day services are rendered. We do not file insurance claims but we will provide you with a "superbill" that contains the diagnosis and procedure codes required for insurance reimbursement. Medical Age Management assumes no responsibility for services not reimbursed by your insurance company.

HIPPA Patient Consent:

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability And Accountability Act of 1996 (HIPPA). I understand that by signing this consent, I authorized the practice to use and disclose my protected health information (PHI) to carry out the following:

- Treatment (including direct and indirect treatment by other healthcare providers involved in my treatment).
- Obtaining payment from third party payers. (e.g. my insurance company).
- The day-to-day healthcare operations. I have been informed of and given the right to review and secure a copy of the privacy statement, which contains more complete description of the uses and disclosures of my PHI and my rights under HIPPA.
- I understand that the practice reserves the right to change the term of this notice at any time and that I may contact the practice at any time to obtain the most current copy of this notice.
  I understand that I may revoke this consent at any time. However, any use or disclosure that occurred prior to the revocation date is not affected.

HIPPA E-mail Consent:

Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once you receive it, someone may be able to access your email account and read it. Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA. The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email. Check the box below if you do NOT want to communicate by email about your health. Other wise, you will be saying that you understand the risks of unencrypted email and do hereby give permission to the Medical Age Management to send me personal health information via unencrypted email.

☐ I do not wish to receive personal health information via email.

Cancellation Policy:

I may cancel or change my appointment time up to 24 hours in advance of my session. After that time, I will be charged $50.00.

I have read, understand, and agree to the above policies:

_____

Please Print Your Name

_____

Signature Date

Current Health Concerns

Please list by order of importance to you. (Attach another list if necessary)	How long has this been a problem?	Have you sought diagnosis or treatment for this issue before? If yes, please describe:
1.		
2.		
3.		
4.		

Past Medical History

Please list any hospitalizations and any previously diagnosed illnesses or injuries (eg, cardiovascular disease, broken bones, surgeries, etc):
1. Year occurred/diagnosed:
2. Year occurred/diagnosed:
3. Year occurred/diagnosed:
4. Year occurred/diagnosed:

Allergies

Any known medication/environment/foods allergies? (circle) Y/N

If Yes, which medications/environment/food allergies: _____

_____

What allergic reaction symptoms do you experience? _____

_____

Prescribed medications and over the counter medications – attach a separate list if necessary

Medication Name	Dose	When started?	Why?
1.			
2.			
3.			
4.			

Supplements – please list all vitamins/botanicals, homeopathics, etc.
Please include vendor if the product is a proprietary blend/combo product – attach a separate list if necessary.

Product name	Dose	When started	Why
1.			
2.			
3.			
4.			
5.			

Family Health History

Please indicate if a parent, grandparent, child, or sibling has had any of the following health problems: allergies, arthritis, asthma, cancer, depression or other mental illness, diabetes, drug or alcohol abuse, headaches, heart disease, high blood pressure, kidney disease, thyroid disease, neurological conditions, or other genetic diseases:

Grandparents: Please list any illness

Mother's mom: _____

Fathers mom: _____

Mother's Dad: _____

Father's Dad: _____

Children:
Gender: Age(s): Illnesses:

1._____

2._____

3. _____

4. _____

Mother: ❑ Living ❑ Deceased Age:____

Cause if deceased: _____

Father: ❑ Living ❑ Deceased Age:_____

Cause if deceased: _____

Sibling: Y/N Number living:
Number deceased:
Gender: Age(s): Cause(s) if deceased:

1._____

2._____

3._____

4.

Review Of Systems – Check/Circle appropriate responses below				
Neuro-Endocrine:	**Past**	**Current**	**1 – Mild 2 – Moderate 3 – Severe**	**Notes:**
Fever	❑	❑		
"Brain Fog"/ Memory difficulty	❑	❑	1 2 3	
Depression	❑	❑	1 2 3	Thoughts of Suicide?
Irritability	❑	❑	1 2 3	
Anxiety/Nervousness	❑	❑	1 2 3	
Panic Attacks	❑	❑	1 2 3	
Fatigue	❑	❑	1 2 3	Recent onset or Chronic? Hard time getting up in the morning? Y or N Do you feel tired through out the day? Y or N Does your energy drop during the day? Y or N
Trouble Falling asleep	❑	❑		
Wake up during the night	❑	❑		What wakes you up (eg. Thoughts or bathroom)?
Trouble concentrating	❑	❑	1 2 3	
Can't tolerate noise	❑	❑	1 2 3	
Sensitive to light	❑	❑	1 2 3	
Sensitive to smells	❑	❑	1 2 3	
Vertigo/dizziness	❑	❑	1 2 3	
Fainting	❑	❑	1 2 3	
Tremors	❑	❑	1 2 3	
Numbness in limbs	❑	❑	1 2 3	
Seizures	❑	❑	1 2 3	
Thirst ❑ Lack of ❑ Excessive	 ❑ ❑	 ❑ ❑	 1 2 3 1 2 3	
Appetite ❑ Lack of ❑ Excessive	 ❑ ❑	 ❑ ❑	 1 2 3 1 2 3	
Craving for ❑ Salty foods ❑ Sugar	❑ ❑	❑ ❑		
Hypoglycemia - need to eat often or feel weak, irritable shaky	❑	❑	1 2 3	
Weight ❑ Gain ❑ Loss	 ❑ ❑	 ❑ ❑	 1 2 3 1 2 3	How much did you weigh last yr? 5 years ago? 10 years ago? What is your ideal weight? Where in body have you gained/loss the weight? ❑ belly fat ❑ waist ❑ Face ❑ breast ❑ all over ❑ other:
Sweat ❑ Lack of ❑ Excessive	 ❑ ❑	 ❑ ❑	 1 2 3 1 2 3	
Hands & feet feel cold	❑	❑		
Sensitive to cold	❑	❑		

Head:	**Past**	**Current**	**1 – Mild 2 – Moderate 3 – Severe**	**Notes:**
Hair ❑ Dry ❑ Thinning ❑ Excessive shedding ❑ Balding	❑	❑	1 2 3	Hair loss Where? ❑ Top of head ❑ Male pattern ❑ Underarms ❑ Pubic area
Headaches	❑	❑	1 2 3	Location of pain? Sensation of pain?
Migraines	❑	❑	1 2 3	
Eyes:				
Dryness	❑	❑	1 2 3	
Discharge	❑	❑	1 2 3	
Tearing	❑	❑	1 2 3	
Cataract	❑	❑	1 2 3	
Glaucoma	❑	❑	1 2 3	
Vision ❑ Change in vision ❑ Near sighted ❑ Far sighted ❑ Blurry vision	❑	❑		
Under eye bags /dark circles	❑	❑	1 2 3	
Ears:				
Pain in Ears	❑	❑	1 2 3	
Ear infections	❑	❑	1 2 3	
Excessive ear wax build-up	❑	❑	1 2 3	
Hearing Loss	❑	❑	1 2 3	
Tinnitus	❑	❑	1 2 3	
Nose:				
Nasal congestion	❑	❑	1 2 3	
Nasal dryness	❑	❑	1 2 3	
Nose runs	❑	❑	1 2 3	
Nose bleeds	❑	❑	1 2 3	
Post-nasal drip	❑	❑	1 2 3	
Sinus pressure	❑	❑	1 2 3	
Sinus infections	❑	❑	1 2 3	
Mouth/Throat:				
Canker sores/ Oral lesions	❑	❑	1 2 3	
Periodontal disease	❑	❑		
Gums receding	❑	❑		
Amalgam fillings	❑	❑	1 2 3	How many?
Sore throat	❑	❑	1 2 3	
Difficulty swallowing	❑	❑	1 2 3	
Hoarse voice	❑	❑	1 2 3	
Cardiovascular:	**Past**	**Current**	**1 – Mild 2 – Moderate 3 – Severe**	**Notes:**
Shortness of breath	❑	❑	1 2 3	
High blood pressure	❑	❑	1 2 3	
Low blood pressure	❑	❑	1 2 3	

Chest pain	❑	❑	1 2 3	
Palpitations/"flutters"	❑	❑	1 2 3	
Heart rhythm abnormalities ❑ Fast Heart Beat ❑ Slow heart Beat	❑	❑	1 2 3	
Murmur	❑	❑	1 2 3	
Poor circulation: cold hands/feet	❑	❑	1 2 3	
Varicose veins	❑	❑	1 2 3	
Leg cramps	❑	❑	1 2 3	
Loss of hair on lower limbs	❑	❑	1 2 3	
Respiratory:				
Cough	❑	❑	1 2 3	
Wheezing	❑	❑	1 2 3	
Bronchitis	❑	❑	1 2 3	
Pneumonia	❑	❑	1 2 3	
Positive TB test	❑	❑	1 2 3	
Immune system:				
Frequent colds/ flu	❑	❑	1 2 3	
Long recovery time from illness	❑	❑	1 2 3	
Frequent antibiotic use	❑	❑	1 2 3	
Chronic inflammation	❑	❑	1 2 3	
Chronic viral infections (EBV, CMV, HIV, etc.)	❑	❑		
Swollen glands	❑	❑	1 2 3	
Night sweats	❑	❑	1 2 3	
Gastro-Intestinal:				
Acid reflux/heartburn	❑	❑	1 2 3	
Abdominal pain	❑	❑	1 2 3	
Constipation	❑	❑	1 2 3	
Diarrhea	❑	❑	1 2 3	
Ulcer(s)	❑	❑	1 2 3	
Intestinal cramping	❑	❑	1 2 3	
Abdominal bloating	❑	❑	1 2 3	
Belching	❑	❑	1 2 3	
Nausea	❑	❑	1 2 3	
Vomiting	❑	❑	1 2 3	
Flatulence	❑	❑	1 2 3	
Itching anus	❑	❑	1 2 3	
Blood in stools	❑	❑	1 2 3	
Rectal pain	❑	❑	1 2 3	
Hemorrhoids	❑	❑	1 2 3	
Fissures	❑	❑	1 2 3	
Genito-Urinary:				
Frequent urination	❑	❑	1 2 3	❑ Day ❑ Night
Urinary incontinence	❑	❑	1 2 3	❑ Day ❑ Night
Blood in urine	❑	❑	1 2 3	How long?
Urinary tract infections	❑	❑	1 2 3	
Pain during urination	❑	❑	1 2 3	

Do you lack sexual desire?	❑	❑	1 2 3	❑ Increased ❑ Decreased
Sexually active	❑	❑		If Y, frequency of sexual activity? Number of partners in the last year? Satisfied with your sex life? Y/N
Pain during intercourse	❑	❑	1 2 3	
Sexually transmitted infections	❑	❑		❑ HIV ❑ Herpes ❑ HPV/Warts ❑ Gonorrhea ❑ Chlamydia ❑ Syphilis ❑ Hepatitis
Impaired fertility	❑	❑		
Musculoskeletal:				
Joint ❑ Pain ❑ Stiffness	❑	❑	1 2 3	Where? In the morning, only?
Arthritis	❑	❑	1 2 3	
Osteoarthritis	❑	❑	1 2 3	
Back pain	❑	❑	1 2 3	Location (upper, middle, lower)?
Neck Pain	❑	❑	1 2 3	
Muscle ❑ Weakness ❑ Pain ❑ Stiffness ❑ Tenderness	❑	❑	1 2 3	
Fibromyalgia	❑	❑		
Loss of muscle ❑ Tone ❑ Mass	❑	❑	1 2 3	
Slow recovery after exercise	❑	❑	1 2 3	
Skin:				
Quality				❑ Dry ❑ Oily ❑ Normal ❑ Thin ❑ Itchy
Bruise easily	❑	❑	1 2 3	
Hives	❑	❑	1 2 3	
Rashes	❑	❑	1 2 3	
Frequent fungal Infections	❑	❑		
Bumpy skin	❑	❑	1 2 3	
Flaky scalp	❑	❑	1 2 3	
Psoriasis	❑	❑	1 2 3	
Eczema	❑	❑	1 2 3	
Acne	❑	❑	1 2 3	
Precancerous/ Cancerous growths	❑	❑		
Moles	❑	❑		
Warts	❑	❑		
Female Health:				
Breast tenderness	❑	❑	1 2 3	
Breast lumps/ cysts	❑	❑	1 2 3	
Swollen breast				
Vaginal symptoms:				Date of last gynecologic exam:
Itchiness	❑	❑	1 2 3	
Discharge	❑	❑	1 2 3	Ever had an abnormal pap? Y/N
Odor	❑	❑	1 2 3	
Dryness	❑	❑	1 2 3	If yes, when?
Lacerations/tears	❑	❑	1 2 3	

Vaginal symptoms:				Date of last gynecologic exam:
Itchiness	❑	❑	1 2 3	
Discharge	❑	❑	1 2 3	Ever had an abnormal pap? Y/N
Odor	❑	❑	1 2 3	
Dryness	❑	❑	1 2 3	If yes, when?
Lacerations/tears	❑	❑	1 2 3	
Yeast infections	❑	❑	1 2 3	
Bacterial vaginosis	❑	❑	1 2 3	
PMS	❑	❑	1 2 3	❑ Water retention? ❑ Bloating? ❑ Sugar Cravings? ❑ Acne? ❑ Irritability? ❑ Painful/swollen Breast? ❑ Other:
Menstrual cramps	❑	❑	1 2 3	
Irregular bleeding	❑	❑	1 2 3	*Blood flow:* how many days? ❑ Light ❑ Medium ❑ Heavy ❑ Large clots
Mood volatility	❑	❑	1 2 3	
Irritability	❑	❑	1 2 3	
Weepiness	❑	❑	1 2 3	
Endometriosis	❑	❑	1 2 3	
Uterine fibroids	❑	❑	1 2 3	
Ovarian cysts	❑	❑	1 2 3	
Hot flashes/sweats	❑	❑	1 2 3	❑ Day ❑ Night
Vertical wrinkles above lips	❑	❑		
Face is too hairy	❑	❑	1 2 3	

Reproductive history: Number of pregnancies: Number of miscarriages: Number of abortions: Number of births: Date of last birth:	Date of last menstrual period: *How many days between periods?* ❑ Short ❑ Long ❑ Irregular

Birth Control, Oral contraceptives, HRT/BHRT or other hormone treatment/ replacement used? Y/N	If so, what has been used and how long?

Male Health:	**Past**	**Current**	**1 – Mild 2 -Moderate 3 – Severe**	**Notes:**
Scrotum:				History of undescended testes? Y/N
Epididymitis	❑	❑	1 2 3	
Varicocele	❑	❑	1 2 3	Do you do self- testicular exams? Y/N
Pain/Lump	❑	❑	1 2 3	
Erectile Dysfunction	❑	❑		
Breast getting fatty	❑	❑	1 2 3	
Sexual performance decrease	❑	❑	1 2 3	
Sensation of not emptying your bladder completely	❑	❑	1 2 3	
Increase in Urination	❑	❑	1 2 3	How often urinate during the day? (every hr, 2hr..)
Stopped & started again several times during	❑	❑	1 2 3	