An Optimal You
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Medical History
Hormone Optimization Consultation

Date	Name	D.O.B

My Primary Health Concerns

My Current Medical Problems

Allergies

Medication Sensitivities / Reactions

Current Medications - Prescription & Non-prescription (name/dose/reason for taking)	
Current Supplements (names and doses)	

Hospital Admissions / Surgeries (Not including pregnancies)			
Year	Illness/Operation	Year	Illness/Operation

Screening Tests					
Screen	Date	Results?	Screen	Date	Results?
Cholesterol/Lipids			Dental Exam		
Blood Sugar			Eye Exam		
Pap Smear			Skin Exam		
Mammogram			Colonoscopy		

Bone Density			PSA (prostate test)		
Vascular Ultrasound			Prostate Exam		

Immunizations

Immunization	Date	Immunization	Date	Immunization	Date
Tetanus/Td		Pneumonia		Varicella	
Influenza (FLU)		Hepatitis			

Family History

Check boxes if a blood relative has suffered any of the following – indicate which relative(s), and give details below

1. ☐ Anemia	2. ☐ Alcoholism	3. ☐ Alzheimer's	4. ☐ Arthritis
5. ☐ Asthma	6. ☐ Bleeds easily	7. ☐ Cancer (type)	8. ☐ Diabetes
9. ☐ Epilepsy	10. ☐ Glaucoma	11. ☐ Hay fever	12. ☐ Heart disease
13. ☐ Hepatitis	14. ☐ Hypertension	15. ☐ Lipid disorder	16. ☐ Mental illness
17. ☐ Osteoporosis	18. ☐ Stroke	19. ☐ Thyroid dx	20. ☐

Has your mother had a hip fracture after age 50?: ☐Yes ☐ No

Family History Details (indicate the number above, which relative(s) and explain):

Medical History

Enter '**X**' and indicate age or dates for all questions which have ever applied to you.

'**C**' for current ongoing problems, providing dates and details

	Decreased Hearing		Abdominal pain - chronic

	Ringing in ear		Gall bladder trouble
	Ear infections – frequent		Jaundice / Hepatitis
	Dizzy spells		Have bowel movement every _____day(s)
	Fainting spells		Frequent: ☐ Constipation ☐ Diarrhea
	Failing vision		Diverticulosis
	Eye pain		Crohn's / Colitis
	Double or blurred vision		Bloody or tarry stools
	Nose bleeds – recurrent		Hemorrhoids
	Sinus trouble		Hernia; type-
	Sore throats – frequent		Urination – Overactive bladder
	Hoarseness – prolonged		Overnight > than twice
	Dental problems:		More than 8 times/24 hrs.
	Floss teeth _____ times per week		Urgency to urinate
	Hay fever / Allergies		Decrease in urinary force/flow
	Pneumonia / Pleurisy		Painful urination
	Bronchitis / Chronic cough		Urine leakage with: Exercise/ /Straining/Cough
	Shortness of breath: ☐ Exertional ☐ Lying flat		Blood in urine
	Asthma / Wheezing		Kidney stones
	Chest pain		Urine infections – frequent
	High blood pressure		Sexually transmitted diseases:
	Heart murmur		Recent weight- ☐Gain ☐ Loss: lbs.
	Rapid heart beat		Desired weight: lbs.

	Swollen ankles		Anemia
	Irregular pulse		Bruise easily
	Palpitations		Blood transfusions
	Leg pain – when walking		Cancer; type(s)-
	Varicose Veins / Phlebitis		Chronic fatigue
	Cold numb feet		Diabetes

	Loss of appetite – recent		Seizures
	Difficulty swallowing		Stroke
	Heartburn		Tremor / hands shaking
	Peptic ulcer		Numbness / tingling sensations
	Persistent nausea / Vomiting		Headaches – frequent
	Bone fracture / joint injury		Arthritis; type/location:
	Fractures after age 50? ☐Yes ☐No		Back pain – recurrent
	Foot pain		☐ Coffee _____ ☐ Tea _____ cups/day
	Osteoporosis		Alcohol: ☐Never ☐Rarely ☐Weekly ☐Daily
	Gout		☐Beer ☐Wine ☐Liquor; # drinks:
	Rashes		Gotten drunk in the past month? ☐ Yes ☐ No
	Hives		Felt the need to stop drinking? ☐ Yes ☐ No
	Psoriasis		Smoking:# cigars/cigarettes/day; yrs
	Eczema		Year quit smoking:
	Sleeping difficulty		Recreational drugs:
	Concentration difficulty		☐ Acupuncture ☐ Tattoos
	Depression		Abuse: ☐ Physical ☐ Sexual ☐ Other
	Nervousness		Hair loss: ☐Progressive ☐Recent

	Agitation		Do you have a lack of energy?
	Memory loss		Do you have less strength/endurance?
	Moodiness		Have you lost height? inches
	Suicidal thoughts		Decreased "enjoyment of life?"
	Phobias		Are you sad and/or grumpy?
	Mental illness		Recent deterioration in ability to play sports?
	Feelings of worthlessness		Are you falling asleep after dinner?
	Rheumatic Fever		Recent deterioration in work performance?
	Scarlet Fever		Do you have a decrease in libido?
	Chicken Pox		Satisfied with orgasm frequency? ☐ Yes ☐ No
	Polio		Are you sexually active? Past Current
	Mumps		Opposite sex ☐ ☐
	German measles		Same sex ☐ ☐
	Tuberculosis		Single partner ☐ ☐
	Herpes		Multiple partners ☐ ☐
	Aids / HIV		# of sex partners in past year:_____
	Thyroid disease		_____

Females (complete the following section)

Age when you started menstrual periods: _____	Pregnancies: _____
If menopausal, date of your last period: _____	Abortions: _____
Date of the 1st day of your last period: _____	Miscarriages: _____
Periods start every____ days; # of days of flow:____	Live births: _____ Age at 1st delivery: _____
Periods: ☐Regular ☐Irregular ☐Pain/Cramps	Did you ever breast feed? Yes ☐ No ☐
Pain / Bleeding during or after sex: ☐ Yes ☐ No	Birth control method: _____

Females- check only those symptoms you currently experience:

☐	Mental fogginess	☐	Increase of breast size
☐	Forgetfulness	☐	Water retention
☐	Depression	☐	Impatient, snappy behavior
☐	Minor anxiety	☐	Pelvic cramps
☐	Mood change	☐	Nausea

Females (continued)

Check only those symptoms you <u>currently</u> experience:

☐	Difficulty falling asleep	☐	Flabbiness and muscular weakness
☐	Hot flashes	☐	Loss of hair
☐	Night sweats	☐	Lack of energy and stamina
☐	Temperature swings	☐	Loss of coordination and balance
☐	Day-long fatigue	☐	Decreased sex drive
☐	Decreased sense of sexuality	☐	Decreased hair - armpit, pubic, body
☐	Lessened self-image	☐	Harder to reach climax
☐	Dry eyes, skin and vagina	☐	
☐	Sagging breasts and loss of fullness	☐	
☐	Pain with sexual activity	☐	

How do/did you feel during different days of the month of your cycle?

How do/did you feel a few days before and during the period?

How do/did you feel from the day of ovulation to the onset of heavy flow?

Did you develop signs of deficiency after starting birth control pills?

Did you feel miserable, gain weight or did breast size increase after starting birth control pills?

Did you feel better after starting birth control pills?

Males (complete the following two sections)

Symptoms at this time	**None**	**Mild**	**Moderate**	**Severe**	**Extreme**

Decline in your feeling of general well-being	☐	☐	☐	☐	☐
Joint pain and muscular ache	☐	☐	☐	☐	☐
Excessive sweating	☐	☐	☐	☐	☐
Sleep problems	☐	☐	☐	☐	☐
Increased need for sleep, often feeling tired	☐	☐	☐	☐	☐
Irritability	☐	☐	☐	☐	☐
Nervousness	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐
Physical exhaustion / lack vitality	☐	☐	☐	☐	☐
Decrease in muscular strength	☐	☐	☐	☐	☐
Depressive mood	☐	☐	☐	☐	☐
Feeling that you have passed your peak	☐	☐	☐	☐	☐
Feeling burnt out, having hit rock bottom	☐	☐	☐	☐	☐
Decease in beard growth	☐	☐	☐	☐	☐
Decrease in ability / frequency to perform sexually	☐	☐	☐	☐	☐
Decrease in the number of morning erections	☐	☐	☐	☐	☐
Decrease in sexual desire / libido	☐	☐	☐	☐	☐

Over the past month how often have you:	**Not at All**	**< 1 time in 5**	**< 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 hrs. 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?	☐	☐	☐	☐	☐	☐

Nutrition

List any diets you have been on during the past 12 months, along with the reason(s) for following it, the benefits or problems you experienced with it, and the reason(s) for stopping any diet:

Exercises

Current Sources of Stress

Miscellaneous

Additional information you would like to share, or to elaborate on previous questions

Patient Signature:	**Date:**