Southern California Center for Anti-Aging
Hormone Replacement Therapy | Medical Weight Loss

MEDICAL HISTORY/LIFESTYLE ASSESSMENT

Date: _____

Name: _____
Last First

Phone: Home: _____ Cell: _____

Work: _____ Fax: _____

Email: _____

Date of Birth: _____ Age: _____ Sex: _____

Height: _____ Weight: _____

Marital Status: _____ No. of Children: _____

Occupation: _____

Address:

Number/Street: _____ City: _____

State: _____ Zip: _____

Pets (please list):
_____

Primary Care Physician:

Name: _____

Address: _____

Telephone: _____

May we contact this practitioner? Yes ____ No ____

Who referred you: _____

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What is your main reason for seeking consult today?

_____
_____
_____
_____

Please list any current medical problems:

_____
_____
_____
_____

Surgical procedures (please list any and all major or minor surgical procedures and the dates the procedures were performed):

_____
_____
_____
_____

Allergies to food or medication? If yes, please list:

_____
_____
_____
_____

Please list the names, dosage, frequency, and duration of all medications you are currently taking:

Name (How long?)	Dosage	Frequency

Please describe any neutraceutical, herbal or other OTC supplements you are currently taking, including:

Type	Dosage	How Long?

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MEDICAL HISTORY (SELF)

Your Past Medical History (circle all that apply to you):	*Diagnosis (list if applicable and any other useful information):*
Headaches	_____
Cancer (where, which type)	_____
Diabetes	_____
Heart Disease	_____
Arthritis	_____
Liver Disease	Hepatitis, cirrhosis, other _____
High blood pressure	_____
Elevated cholesterol	_____
Mental Concerns	Depression, anxiety, panic attacks, maniac depression, schizophrenia, other _____

HIV/AIDS

Endocrine gland abnormalities

Thyroid, pituitary, other

Loss of energy

Decreased self image

Back/spine concerns

Sleep concerns

Neurological condition (stroke, seizures, Parkinson's disease, memory concerns, Alzheimer's disease, other):

Autoimmune Disease (lupus, rheumatoid arthritis, other):

Lung Disease (asthma, emphysema, other):

Kidney Disease (stones, infection, other):

Stomach Disease (ulcers, other):

Bowel Disease (lactose intolerance, Crohn's disease, diverticulitis, malabsorption, other):

Bladder Disease (loss of control, infections, other):

Memory Problems (short term memory, long term memory, please describe):

Sexual Concerns (please describe):

Exposure to chemicals or other toxins:

Exposure to excessive stress:
_____
_____
_____

Osteoporosis:
_____
_____
_____

Balance concerns:
_____
_____
_____

Decreasing vision:
_____
_____
_____

Carpal tunnel:
_____
_____
_____

Sensory concerns(numbness, tingling, loss of feeling):
_____
_____
_____

Slow or poor wound healing:
_____
_____
_____

Frequent infections:
_____
_____
_____

Date of last chest x-ray:
_____
_____
_____

Date of last digital rectal exam:
_____
_____

Date of last cardiac stress test:
_____
_____
_____

Date of last colonoscopy/sigmoidscopy:
_____
_____
_____

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WOMEN'S HEALTH (women only)

Have you ever used oral contraceptives? _____

If yes, please describe: _____

When was you last period: _____

Since you first began to have periods, have you ever had what YOU consider to be abnormal cycles?
_____

Any problems with oral contraceptives? _____
If yes, please explain:_____

Do you have or did you ever have premenstrual syndrome?
_____

How many pregnancies have you had? _____ How many children? _____

How many interrupted pregnancies? _____

Have you had a hysterectomy? _____ If yes, provide date of surgery: _____

Have you had ovaries removed? _____ If yes, provide date of surgery: _____

Have you had a tubal ligation?: _____ If yes, provide date of surgery: _____

Date of last PAP smear and results:
_____

Date of last mammogram and results:
_____

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MEN'S HEALTH (men only)

Any difficulty in maintaining/attaining an erection (or insufficient to maintain penetration)?
_____

Ejaculation cause pain? _____ Pain/coldness in genital area? _____

Discharge from penis? _____

Sexual drive underactive? _____ Sexual drive overactive? _____

Premature ejaculation? _____

Infertility? _____ Low sperm count? _____

Past or present rash on penis? _____ Swollen genitals? _____

Swelling in groin? _____

Any past or present genital sores? _____ Jock Itch? _____

Past or present sexually transmitted diseases? _____
If yes, please describe: _____

Do you use Viagra or Cialis? _____ If yes, how often? _____
Has it helped you?_____

Do you use any other medications for sexual function? _____
If yes, please list and describe results: _____

Date of last prostate exam: _____

Date of last PSA: _____

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FAMILY HISTORY

#RELATIVE	AGE OR YEAR OF DEATH (Current age and health conditions; if deceased, please list age at death and cause of death)
Mother	
Father	
Siblings	
Children	
Grandchildren	

DO YOU HAVE A FAMILY HISTORY OF ANY OF THE FOLLOWING?

DIAGNOSIS (list if applicable and any other useful information, including which family member(s) experienced the disease and/or symptoms)

Headaches _____
_____

Cancer (where, which type) _____
_____

Diabetes _____
_____

Heart Disease _____
_____

Arthritis _____
_____

Liver Disease _____
_____

Mental Concerns _____
_____

Neurological Disease _____
_____

Autoimmune Disease _____
_____

Lung Disease _____
_____

Kidney Disease _____
_____

Stomach Disease _____
_____

Bowel Disease _____
_____

Osteoporosis _____
_____

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NUTRITION

In the past few months your weight has (circle one):

a) been increasing
b) been decreasing
c) remained the same
d) has been fluctuating up and down

What is the heaviest you have ever weighed (excluding pregnancy)?

a) your present weight
b) around 10 lbs heavier than your present weight
c) between 10-25 lbs heavier than your present weight
d) more than 25 lbs heavier than your present weight

What is the lightest you have weighed since graduating high school?

a) your present weight
b) around 10 lbs lighter than your present weight
c) between 10-25 lbs lighter than your present weight
d) more than 25 lbs lighter than your present weight

What is a realistic goal weight for you to maintain in the future? _____ lbs.

How many meals to you eat per day?
_____

How much water do you drink a day?
_____

Please list any food allergies:
_____
_____
_____
_____

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DRUG USAGE

Marijuana use (how often, how long?):
_____

Alcohol use (how many drinks and frequency):
_____

Tobacco use (what type, how often, how many years):
_____

Cocaine use (mode, how often, how long):
_____

Psychedelic drug use (LSD, ecstasy, other):
_____

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TYPICAL DAILY FOOD INTAKE

List the food consumed you consume on a mindful (good eating) day and an unprepared (bad eating) day. Please be specific, including amount of foods, beverages & supplements.

Mindful Day Wake Up Time:_____ Bed Time: _____

Meal	Time	Food/Beverage & Amount
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		

Unprepared Day Wake Up Time:_____ Bed Time: _____

Meal	Time	Food/Beverage & Amount
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		

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EXERCISE

Please describe your exercise history (types and intensity throughout your life):

_____
_____
_____
_____

What type of physical activity have you participated in within the last 6 months?

_____
_____
_____
_____

What are you short-term and long-term exercise goals?

_____
_____
_____
_____

What type of physical limitations do you have (injuries, mobility issues, etc)?

_____
_____
_____
_____

Describe your current exercise program (type, duration, frequency of cardio, resistance, flexibility):

_____
_____
_____
_____

How do you manage your stress? (meditation, prayer, yoga, tai chi, massage). Please include type, duration, and frequency:

_____
_____
_____
_____