

Past Medical History

Please list any medical problems or illnesses you have had or have. Include any hospitalizations and accidents with approximate dates.

Date	Medical diagnosis, illness, accident

Past Surgical History

Date	Surgery

Medications

Please list ALL prescription medications. Include ALL over the counter medications, **supplements, and vitamins.**

Name of Medication	Dosage	Dosing schedule

Allergies

Are you allergic to ANY MEDICATIONS (prescription and over the counter).

Family History

Please list ALL illness (heart disease, stroke, diabetes, hypertension, cancer (breast, cervical, prostate, lung, skin, blood), etc. If a member is deceased, please list age at death and cause of death if known.

Relationship	Age	Medical problem / Cause of death
Mother		
Father		
Brothers		
Sisters		
Children		
Spouse		

Social History

Please remember this information is strictly confidential and will be used only to address you symptoms and/or complaints.

Do you smoke cigarettes now or have you in the past? Yes No

- If yes, how many packs per day? _____
- How many total years have you smoked? _____

Do you drink alcohol? Yes No

- If yes, how many drinks and what kind (wine, beer, bourbon, etc.) do you have in an average week? _____.

Do you now or have you in the past used any illicit drugs (marijuana, amphetamines, narcotics, psychedelics, cocaine, etc.)? Yes No

- If yes, what substance and how often _____.

Urological History

Date of last prostate exam? _____ Physician who performed? _____

Physician's Phone Number: _____.

Date of PSA blood work/? _____ Facility/Office where performed: _____

Facility/Office Phone Number: _____.

	YES	NO
Have you ever had an abnormal Prostate Exam? If yes, what was the abnormality and what follow up did you have? _____		
Have you ever had an elevated PSA? If yes, what follow up did you have? _____		
Have you ever had a prostate?		

Do you have a history of any of the following **cancers**:

- | | | |
|---|---|---------------------------------|
| <input type="checkbox"/> Lung
<input type="checkbox"/> Breast
<input type="checkbox"/> Colon
<input type="checkbox"/> Prostate | <input type="checkbox"/> Skin
<input type="checkbox"/> Lymphoma
<input type="checkbox"/> Leukemia | <input type="checkbox"/> Other: |
|---|---|---------------------------------|

Hormone Therapy History

Have you been treated with any hormone replacement therapy? If yes, please give approximate periods of treatment:

Hormone	Dose	Reason	Start Date	Stop Date

Androgen Deficiency

- | | |
|---|--|
| <input type="checkbox"/> Low Libido
<input type="checkbox"/> Lack of Energy
<input type="checkbox"/> Decreased Strength / Endurance
<input type="checkbox"/> Lost Height
<input type="checkbox"/> Decreased Enjoyment of Life
<input type="checkbox"/> Sad or Grumpy
<input type="checkbox"/> Problem with Memory / Concentration | <input type="checkbox"/> Decreased Erections
<input type="checkbox"/> Decreased Ability to Play Sports
<input type="checkbox"/> Fall Asleep After Dinner
<input type="checkbox"/> Sleep Disturbances
<input type="checkbox"/> Recent Deterioration in Work Performance
<input type="checkbox"/> Decreased Muscle Mass
<input type="checkbox"/> Hair Loss |
|---|--|

Adrenals		
Check which of these symptoms are troublesome and have persisted over time		
Cortisol Excess		Cortisol Deficiency
<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Bone Loss	<input type="checkbox"/> Headaches	<input type="checkbox"/> Sugar Craving
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Stress	<input type="checkbox"/> Allergies
<input type="checkbox"/> Weight Gain - Waist	<input type="checkbox"/> Cold Body Temperature	<input type="checkbox"/> Chemical Sensitivity
<input type="checkbox"/> Loss of Muscle Mass	<input type="checkbox"/> Sugar Cravings	<input type="checkbox"/> Stress
<input type="checkbox"/> Thinning Skin	<input type="checkbox"/> Low Libido	<input type="checkbox"/> Cold Body Temperature
<input type="checkbox"/> Elevated Triglycerides	<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Irritable
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Increased Body Hair	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Irritable	<input type="checkbox"/> Acne	<input type="checkbox"/> Heart Palpitations
<input type="checkbox"/> Anxious	<input type="checkbox"/> Nervous	<input type="checkbox"/> Aches/Pains
<input type="checkbox"/> Memory		

Thyroid	
Check which of these symptoms are troublesome and have persisted over time	
Thyroid Excess	Thyroid Deficiency
<input type="checkbox"/> Heat Intolerance	<input type="checkbox"/> Cold Intolerance
<input type="checkbox"/> Voice has become horse	<input type="checkbox"/> Constipation
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Fatigued / Weakness
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Unexplained Weight Gain
<input type="checkbox"/> Tremors / Shakiness	<input type="checkbox"/> Inability to Loose Weight
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Stress
<input type="checkbox"/> Nervousness / Anxious / Panic Attacks	<input type="checkbox"/> Cold Body Temperature
<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Irritable
<input type="checkbox"/> Difficulty Conceiving / Infertility	<input type="checkbox"/> Lack of Motivation
<input type="checkbox"/> Coarse Dry Skin	<input type="checkbox"/> Muscle Cramps
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Aches/Pains

System Review – Check the appropriate box for each question.			
Constitutional / ID / Oncology	Yes	No	Not Sure
Have you had unexplained weight loss?			
Do you have fever of chills?			
Do have night sweats?			
Do you notice swollen lymph nodes?			
Have you ever been diagnosed with cancer?			
Have you ever tested positive of HIV?			
Have you ever had a sexually transmitted disease?			
Respiratory			
Do you have a cough?			
Do you frequently sneeze?			
Do you have excessive daytime sleepiness?			
Do you snore?			
Have you ever been diagnosed with asthma or emphysema			

Cardiovascular	Yes	No	Not Sure
Do you have chest pain?			
Do you have palpitations?			
Do you have shortness of breath?			
Do you have swelling in your legs?			
Do you have leg pain while walking?			
Have you been diagnosed with any heart condition?			
Have you ever been diagnoses with a blood clot?			
Gastrointestinal			
Do you have trouble swallowing food?			
Do you have nausea or vomiting?			
Do you have diarrhea?			
Do you have blood in your stool?			
Do you have abdominal pain or swelling?			
Have you ever been diagnoses with hepatitis or liver disease?			
Endocrine			
Do you urinate frequently or in larger amounts than usual?			
Do you have a greater than normal urge to eat?			
Are you excessively thirsty?			
Do you have facial hair?			
Do you have acne?			
Have you ever been diagnosed with a thyroid problem?			
Neurological			
Do you have muscle weakness?			
Have you ever had a seizure?			
Have you ever fainted?			
Have you experienced double vision or blind spots?			
Have you ever been diagnosed with a stroke?			
Urologic / Renal			
Do you have burning when you urinate?			
Do you have urgency when you urinate?			
Do you urinate more frequently than others?			
Do you leak urine when laughing or coughing?			
Have you ever had any kidney problems?			

Physician Notes:

Disclosure / Liability Waiver

Bay Area Aesthetics & Wellness – Bioidentical Hormone Replacement Program integrates guidelines and practice parameters set forth by the FDA, National Institutes of Health, and American Academy of Anti-Aging Medicine. While numerous safety measures are taken by our physicians and staff, incidental events may occur that is beyond the control our staff. Within the medical community, there are opposing views with respect to the use of bioidentical hormonal replacement therapies. The use of bioidentical hormones does provide true medical benefit, and in this setting is being used to lessen/treat symptoms you have identified as bothersome, undesirable, and frankly unwanted. It is therefore expressly agreed that you are voluntarily participating in this program and all bioidentical hormonal replacement regimens, and the use of any medications and/or supplements is undertaken at your own risk. You hereby agree to waive any claims or rights you might otherwise have to pursue legal remedies from Bay Area Aesthetics & Wellness, its staff, or treating providers for injury to you on account of involvement in the Bioidentical Hormone Replacement Program. You have carefully read this waiver and fully understand that it is a release of liability.

I accept all terms and conditions of this offer.

Signature

Date

Print Name

Date