Medical Questionnaire

Please Print Clearly

Name________________________________ Date of Birth_____________

Address____

City_____________________ State_________ Zip_____________________

Occupation_______________ Referred by________________________________

Phone____________________ Fax_______________ Height____________

Weight________ Sex____ E-Mail Address_____________________________

History

Medical Allergies & Types of Reaction____

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Smoker? How much and how long?____

Alcohol? How much and how long?____

Prescription Medicines (list names and dosages)_________________________________

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Vitamins, Minerals, & Supplements (Non-prescription)___________________________

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List all hospitalizations and surgeries____

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List all known medical diseases and/or conditions________________________________

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PLEASE CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING

General:

____Significant weight loss or gain
____Irritable
____Depressed
____Tiredness and fatigue
____Angry
____Anxious
____Fever and/or chills
____Insomnia
____Frequently ill
____Night sweats
____Hives
____Cancer/Tumors
____Rashes
____Suicidal
____Other symptoms____

Gastrointestinal: Any known history of gastrointestinal disease? Yes___No___

____Heartburn
____Nausea
____Liver problems
____Difficulty swallowing
____Vomiting
____Jaundice/hepatitis
____Indigestion, bloating
____Diarrhea
____Ulcers
____Change in bowel habits
____Constipation
____Colitis
____Bloody/Tarry stools
____Gallbladder disease
____Other symptoms____

Neurological: Any known history of neurological disease? Yes___No___

____Headache
____Passing out
____Tremors
____Dizziness
____Trouble walking
____Poor memory
____Seizures
____Trouble talking
____Easily confused
____Limb weakness
____Stroke
____Numbness
____Other symptoms____

Musculoskeletal: Any known history of musculoskeletal disease? Yes___No___

____Joint pain
____Bone pain
____Stiffness
____Muscle pain
____Muscle wasting
____Gout
____Muscle weakness
____Hernia
____Other symptoms____

Kidney, Urinary: Any known history of kidney disease? Yes___No___

____Frequent urination
____Dark or bloody urination
____Past kidney infection
____Painful urination
____Known kidney disease
____Past bladder infection
____Incontinence
____Other symptoms______
____Abnormal kidney tests

Eyes, Ears, Nose, and Throat: Any known history of ENT disease? Yes___No___

____Blurred vision	____Sinus infections	____Hay fever
____Loss of vision	____Fever blisters	____Earache or infection
____Ear, throat infections	____Metallic taste	____Nosebleeds
____Glaucoma	____Other symptoms_______________________________________	

Heart and Lungs: Any known history of heart or lung disease? Yes___No___

____Shortness of breath	____High blood pressure	____Tuberculosis
____Chronic cough	____Known heart disease	____Emphysema
____Asthma	____Known heart murmur	____Pneumonia
____Other lung disease	____Skipping heart beats	____Bronchitis
____Chest pain	____Swollen ankles or limbs	
____Heart fluttering	____Other symptoms_______________________________________	

Endocrine, Glandular: Any known history of endocrine diseases? Yes___No___

____Diabetes	____Hypoglycemia	____Frequent urination
____Thyroid problems	____Autoimmune disease	
____Pituitary problems		
____Adrenal problems		

Vascular, Blood: Any known history of blood or vascular disease? Yes___No___

____Anemia	____Bleeding or blood clotting	____Blood transfusion
____Limb pain with walking	____Varicose veins	

Infectious Diseases: Any known history of infectious diseases? Yes___No___

____Diphtheria	____Whooping cough	____Frequent colds
____Rheumatic fever	____Measles	____Lyme’s disease
____Mumps	____Chickenpox	____Tetanus
____Strep throat	____Tonsillitis	____Malaria
____Polio	____Other infections	____HIV

Dental Conditions:

____Dentures	____Extracted wisdom teeth	____Other extractions
____Crown(s)	____Bridges	____Implants
____Gum disease	____Plaque accumulation	____Partial plate
____Root canals	____Fillings	____Bad breath
____Brush regularly	____Floss regularly	____Irrigation (Waterpic)
____Swollen neck glands	____Abscessed tooth	____Fluoride toothpaste

Are you a vegetarian?____How often do you eat seafood?__________________________

How many cups of coffee and other caffeinated beverages do you drink daily?____

Do you use artificial sweeteners?____Which ones?________________________________

History of high cholesterol?____Other known abnormal blood tests?_________________

Are you presently dieting?_____Are you presently exercising?______

Is there anything else that you wish to bring to the attention of the doctor during this initial office visit?____

FEMALES:

Date of last period__________

____Pregnant now or possibly pregnant now

____Bleeding between periods

____Birth control pills

____Hormone therapy

MALES

Have you had a PSA (Prostate Specific Antigen) test? If so, date and result of most recent test____

Regarding HGH therapy:

Please describe your goals and expectations for your program of HGH therapy.

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