Rejuve HEALTH CLINICS

Through our desire to provide you with an exceptional and personalized healthcare experience, we would like to understand the primary symptoms that have brought you to the clinic today. Please take a moment to identify which of the following you are hoping to address through your care at Rejuve Health Clinics.

(Please assign a numerical value from 1-6 to each goal in order of importance)

☐ Improve Energy ☐ Weight Loss ☐ Improve Physical Stamina/Endurance

☐ Increase in Sex Drive ☐ Improve Sexual Function ☐ Management of Chronic Illness: (Cardiovascular disease, Type II diabetes, other)

Patient Information:

How did you hear about our clinic? ☐Web Search ☐Social Media ☐Friend/Family ☐Other _____

First name: _____ Last name: _____ MI: _____

Preferred Name: _____

Address: _____

City, State, Zip: _____

DOB: _____ Age: _____ Height: _____ Weight: _____

SS#: _____ Email: _____

Home Number: _____ Cell: _____

May we send you a text message to remind you of your appointment? **YES** **NO**

May we contact you by email? **YES** **NO**

Emergency Contact: _____ Phone: _____

Primary Care Provider: _____ Phone: _____

I authorize the medical staff of Rejuve Health Clinics to obtain a blood sample expressly for the purpose of determining my testosterone and PSA levels, as well as any additional appropriate laboratory testing.

Signature: _____ Date: _____

Report of Medical History

Patient Name: _____

Statement of patients' present health:
List medications currently used:
List Allergies:

Have you ever?			Do you?		
YES	NO	(PLEASE CHECK EACH ITEM)	YES	NO	(PLEASE CHECK EACH ITEM)
		Lived with anyone who had tuberculosis			Wear glasses or contacts
		Coughed up blood			Have vision in both eyes
		Bled excessively after injury or tooth extraction			Wear a hearing aid
		Attempted suicide			Stutter or stammer habitually
		Been a sleepwalker			Wear a brace or back support

Have you ever or do you now have?

YES	NO	Don't Know	(PLEASE CHECK EACH)	YES	NO	Don't Know	(PLEASE CHECK EACH)	YES	NO	Don't Know	(PLEASE CHECK EACH)
			Scarlet fever, erysipelas				Leg cramps				Recurrent back pain
			Rheumatic fever				Frequent indigestion				Foot trouble
			Swollen or painful joints				Stomach, liver, intestinal problems				Neuritis
			Frequent sever headaches				Gallbladder or gallstones				Paralysis (include infantile)
			Dizziness or fainting spell				Jaundice or hepatitis				Epilepsy or fits
			Eye problems				Adverse reaction to serum, drug, or medicine				Car, Train, or Sea sickness
			Ear, nose, throat trouble				Broken bones				Frequent trouble sleeping
			Hearing loss				Tumor, growth, cyst, cancer				Depression or excessive worry
			Chronic or frequent colds				Rupture/hernia				Loss of memory or amnesia
			Severe tooth or gum trouble				Piles or rectal disease				Nervousness
			Sinusitis				Frequent or painful urination				Periods of unconsciousness
			Hay fever				Bed wetting since age 12				Considering having any (or more) children
			Head injury				Kidney stones or blood in urine				
			Skin disease				Sugar or albumin in urine	**FEMALES ONLY**			
			Thyroid Disorders				Venereal Disease-Syphilis, Gonorrhea, Herpes etc.				Been treated for female disorders
			Tuberculosis				HIV/AIDS				Had a change in periods
			Asthma				Recent gain/loss of weight				Ovarian Cysts
			Shortness of breath				Arthritis, rheumatism, bursitis				Pregnant/breastfeeding
			Pain or pressure in chest				Bone, joint, or other deformity	**Are you? (CHECK ONE)**			
			Chronic cough				Lameness	☐ Right Handed			
			Palpating / pounding heart				Loss of finger or toe				
			Heart trouble				Painful shoulder or elbow	☐ Left Handed			
			High/low blood pressure				Locked knee				

Patient History Questionnaire (Circle Yes or No)

Past History: (Circle Yes or No)

Yes **No** Do you have or have you ever had thyroid disease? **If yes, date:** _____

Yes **No** Do you have or have you ever had diabetes? **If yes, date:** _____

Yes **No** Do you have or have you ever had asthma or lung disease? **If yes, date:** _____

Yes **No** Do you have or have you ever had acne or dry/oily skin? **If yes, date:** _____

Yes **No** Do you have or have you ever had venereal diseases? **If yes, date:** _____

Yes **No** Have you ever had an abnormal PSA test or prostate exam? **If yes, date:** _____

Yes **No** Have you ever had any surgery on the prostate or genital area? **If yes, date** _____

Yes **No** Do you have or have you ever had high blood pressure? **If yes, date:** _____

Yes **No** Have you ever had a heart attack or stroke? **If yes, date:** _____

Yes **No** Have you ever experienced difficulty with phlebotomy? **If yes, explain:** _____

_____

Family History: (Circle Yes or No)

Yes **No** Do you have any blood related family members with breast cancer?

Yes **No** Do you have any blood related family members with prostate cancer?

Yes **No** Do you have any blood related family members with diabetes?

Yes **No** Do you have any blood related family members with cardiovascular disease?

Social History (Circle Yes or No)

Yes **No** Do you use tobacco? **If yes, how much:** _____

Yes **No** Do you drink alcoholic beverages? **If yes, how much/how often:** _____

Signature: _____ Date: _____

Hormone Replacement Questionnaire (Circle Yes or No)

Yes **No** Have you experienced muscle weakness, fatigue, or loss of muscle mass?

Yes **No** Has your interest in sex (libido) declined?

Yes **No** Has your energy level or stamina declined?

Yes **No** Have you lost self-confidence or motivation?

Yes **No** Have you experienced loss of memory or concentration ability?

Yes **No** Have you experienced sleep disturbances or difficulty breathing while asleep?

Yes **No** Do you have mood swings or depression?

Yes **No** Have you noticed an increase of aggression?

Yes **No** Do you have any breast tenderness or enlargement?

Yes **No** Do you have periodic hot flashes or sweats?

Yes **No** Have you experienced difficulty achieving pregnancy?

Yes **No** Are you considering having any (or more) children?

Signature: _____ Date: _____