

GULF COAST WELLNESS CENTER

General Medical History

Today's Date: _____

Name: _____ Date of Birth: _____

Age: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____

Gender: « » Male « » Female Height: _____ Weight: _____

Marital Status: « » Single « » Separated « » Married « » Divorced « » Widowed

Occupation: _____ « » Full-Time « » Part-Time « » Retired « » Unemployed

How did you hear about Natural Hormone Replacement Therapy: _____

Personal Physician (and phone number): _____

How many children do you have? _____

Have you ever had a mammogram: _____ Date: _____ Results: _____

Have you ever had a bone density test? _____ Date: _____ Result: _____

Medical Status

How would you rate your current health? « » Poor « » Average « » Good « » Excellent

Current Medical Conditions: _____

Current Medications: _____

Over-the-counter medications: Please list all that apply.

« » Pain Reliever « » Aspirin « » Acetaminophen (Tylenol)

« » Naproxen (Aleve) « » Sleep Aids « » Laxatives

« » Diet Aids/Weight Loss « » Acid Blockers « » Decongestants

« » Others _____

Allergies: Please check all that apply.

- Penicillin Morphine Aspirin Pets
 Codeine Sulfa Drugs Nitrates Seasonal
 Food Allergies Others: _____
 No Known Allergies

How often and how much?

- Do you use tobacco? Yes No _____
 Do you use alcohol? Yes No _____
 Do you use caffeine? Yes No _____

Nutritional/Supplements: Please list any products you are using.

- Vitamins (mutli, B Complex, E, C) _____
 Minerals (calcium, magnesium, chromium) _____
 Herbs (Ginseng, Ginko Biloba, Echinacea) _____
 Enzymes (CoQ10, digestive enzymes, papaya) _____
 Other _____

Medical Conditions

Do you current suffer from any of the following illness? Please check all that apply.

Childhood Diseases: _____

Conditions:	Current	N/A	Sibling	Parents	Grandparents
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychlatric Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach/Esophagus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight Control Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoprosis / Weak Bones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Current Symptoms

For Women and Men: Please circle all that apply

Part I

Morning Fatigue	0 1 2 3	Afternoon Fatigue 2-4pm	0 1 2 3
Feel Better after 6pm	0 1 2 3	Increased PMS Symptoms	0 1 2 3
Lack of Energy	0 1 2 3	Mild Depression	0 1 2 3
Muscle Weakness	0 1 2 3	Decreased ability to Stress	0 1 2 3
Irritability	0 1 2 3	Chronic Fatigue	0 1 2 3
Swelling in Ankles	0 1 2 3	Increased Allergies	0 1 2 3

Part II

Poor Memory	0 1 2 3	Constipation	0 1 2 3
Bone Loss	0 1 2 3	Cold Flashes	0 1 2 3
Increased Ear Wax	0 1 2 3	Depression	0 1 2 3
Brittle Nails	0 1 2 3	Oily Skin/Hair	0 1 2 3
Hair Loss	0 1 2 3	Depression	0 1 2 3
Decreased Sex Drive	0 1 2 3	Decreased Muscle Size	0 1 2 3
Headaches	0 1 2 3	Fatigue	0 1 2 3
Decreased Erections	0 1 2 3	Bloating	0 1 2 3
Increased Urine Urge	0 1 2 3	Stress	0 1 2 3

For Women Only: Please circle all that apply.

1st day of last menses:

Regular Cycles	Hysterectomy:	No	Yes	Year:	
Irregular Cycles	Ovaries Removed:	No	One	Both	Year:
No Menstrual Cycles	Currently Pregnant:	No	Yes		

If currently pregnant, list the month of pregnancy:

	0 (none)	1 (mild)	2 (moderate)	3 (severe)	
Indigestion	0 1 2 3		Night Sweats	0 1 2 3	
Headaches	0 1 2 3		Memory Lapse	0 1 2 3	
Increased Gas	0 1 2 3		Bone Loss (Osteoporosis)	0 1 2 3	
Aches and Pains	0 1 2 3		Snoring	0 1 2 3	
Dizzy Spells	0 1 2 3		Hot Flashes	0 1 2 3	
Depression	0 1 2 3		Decreased Sexual Interest	0 1 2 3	
Loss Scalp Hair	0 1 2 3		Increased Joint Pain	0 1 2 3	
Tender Breasts	0 1 2 3		Bloating	0 1 2 3	
Anxious	0 1 2 3		Irritable	0 1 2 3	
Nails Breaking/Brittle	0 1 2 3		Difficulty Sleeping	0 1 2 3	
Mood Swings	0 1 2 3		Increased Urinary Urge	0 1 2 3	

