Patient History Form

Patient Name_____

Address: _____ Apt_____City_____ State_____ Zip_____

Home Phone ( ) _____ Cell Phone ( ) _____

Date of Birth _____/_____/_____ Age_____ Sex_____ Social Security # _____

Emergency Contact_____ Phone Number ( ) _____

How did you hear about us?_____

Medical History

Primary Care Physician: _____ Phone: _____

List any medical problems:

_____

List all prior hospitalizations, surgeries:

_____

List any medications you are taking:

_____

Do you have allergies to medication? Yes ↑No If yes, please list_____

Do you use? ↑tobacco____ ↑alcohol____ ↑IV drugs ____

Which of the following conditions are you currently being treated or have been in the past (Circle or check any that apply):

Heart Disease/Murmur/Angina Shortness of Breath Glaucoma Diabetes High Cholesterol Asthma Seizure Kidney/Bladder High Blood Pressure Lung Problems Stroke

Liver Problems Low Blood Pressure Sinus Problems Headaches Arthritis Heartburn Tonsillitis Cancer Depression Anxiety Anemia Ulcers Thyroid Problems

Seasonal Allergies

Please circle any Family History:

Anemia Cancer Diabetes Glaucoma Heart Disease High Blood Pressure

HIV Disease/Aids Mental Illness Depression Stroke Other: _____

Males: ADAM Questionnaire

Do you have a decrease in libido?	Yes	No
Do you have a decrease in energy?	Yes	No
Do you have a decrease in strength or endurance?	Yes	No
Have you lost height?	Yes	No
Hve you noticed a decreased "enjoyment of life"?	Yes	No
Are you sad or grumpy?	Yes	No
Any difficulty with erection or ejaculation?	Yes	No
Have you noticed a decrease in your ability to play sports?	Yes	No
Are you falling asleep after dinner?	Yes	No
Has there been a recent deterioration in your work performance?	Yes	No

Date of Colonoscopy? _____Date of last prostate and rectal exam? _____

Females: Gynecological History and Symptoms

How many times have you been pregnant? _____ Date of last Pap Smear: _____

Have you had an abnormal Pap Smear? Yes No Diagnosis: _____

Date of Last Mammogram: _____ Results: _____

Have you ever had a breast biopsy? Yes No Biopsy Result: _____

When was your last menstrual period?_____

Are they regular in amount? Yes No Duration? Yes No

- Female symptoms of hormone imbalance:

Hot flashes Yes No Night sweats Yes No Mood swings Yes No

Depression Yes No Weight gain Yes No Trouble sleeping Yes No

Mental fog Yes No Less interest in sex Yes No Pain during intercourse Yes No

Vaginal dryness Yes No Heavy vaginal bleeding Yes No Breast tenderness Yes No

Acne Yes No Dry skin Yes No Excessive hair on face and arms Yes No

Hair loss on head Yes No

CONSENT FOR TREATMENT: I, the patient named above, do request and consent to have Revive MD, LLC and their employees, evaluate and treat the above patient for medical complaint and illnesses. This includes, but is not limited to, taking of medical information, evaluation by physical examination, obtaining of bodily fluids for laboratory testing, the administration of medications for treatment, and any other treatment or evaluation that may be necessary. If, at any time, I do not wish to have these services rendered, I may state so and they will not be provided, but an AMA form may need to be signed by the patient. All of my information will remain confidential. I acknowledge that I have been offered a copy of Revive MD, LLC Notice of Privacy Practices.

CONSENT FOR TEST INFORMATION: □ by checking this box I agree to be contacted by phone and voicemail may be left, and/or by email by our staff regarding your medical treatment and information.

Phone # ____ - ____ - _____ Email:
_____

By signing below, I hereby certify that to the best of my knowledge all information I have furnished on this form is complete, true and accurate, I also understand this agreement between Revive MD, LLC.

Patient Name _____

Signature _____

Date _____/_____/___