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 _____/_____/___