Mullica Hill Anti-Aging and Weight Management Center

Patient History Form **Date:___________**

Please complete this form to the best of your ability. The doctor will review your answers during your visit

Last Name	First	Middle	Date of Birth	Age	M / F

Primary Care Doctor	Office Number	Last Physical Exam

Height	Weight	*For Weight Loss Patients:* Goal Weight	Lowest Adult Weight (after age 18)

Main Reason for Visit	REFERRED BY:

MEDICAL & FAMILY HISTORY

	Self	Family		Self	Family		Self	Family
Seizures			Asthma / COPD			Diarrhea		
Migraines or Headaches			Sleep Apnea			Liver Disease		
Dizziness			Pulmonary Hypertension			Gallbladder Disease/ Stones		
Loss of Consciousness			Shortness of Breath			Ulcers		
Stroke			Irregular Heart Rhythm			Colitis		
Glaucoma			Heart Attack or Angina			Constipation		
Thyroid Disorder			Palpations			Arthritis		
Obesity / Overweight			Heart Valve Disorder			Gout		
Diabetes Mellitus (DM)			Heart Failure (CHF)			Osteopenia or Osteoporosis		
High Blood Sugar			High Blood Pressure			Kidney Disease or Stones		
Abnormal Cholesterol			Rheumatic Fever			Alcohol Abuse		
Insomnia			Tuberculosis			Drug Abuse		
Dementia			HIV			Eating Disorder		
			Caner:(type):			Depression or Anxiety		
Other								

MD Notes:

SURGERIES & HOSPITALIZATIONS

Reason / Diagnosis	**Year**

SPECIALISTS (If Any)

Reviewed by:___________________________________

Mullica Hill Anti-Aging and Weight Loss Center   Patient Name:______________________ DOB:____/____/____

MEDICATION ALLERGIES ☐ *No Known Allergies*

Name of Medication	Reaction

PRESCRIPTION MEDICATIONS

Medication Name	Dose & Frequency	Approx Start Date	Reason for Use

SUPPLEMENTS & OVER THE COUNTER MEDICATIONS

Medication Name	Dose & Frequency	Approx Start Date	Reason for Use

SCREENINGS & TESTINGS

TEST	Last Date Done	Results *(-) or State Findings*
Blood Sugar, Cholesterol		
Colonoscopy		
PAP Smear (women)		
Prostate Exam, PSA (men)		
Cardiac Testing (EKG, echo, stress, etc)		
Trans-vaginal Ultrasound		
Mammography		

Mullica Hill Anti-Aging and Weight Loss Center Patient Name:______________________ DOB:____/____/____

***FEMALE** patients: Please check all that apply*

	NONE	MILD	MODERATE	SEVERE
Sleep Disorder				
Anxiety /Nervousness				
Irritability				
Depression / Emotional Swings				
Food Cravings				
Hot Flashes				
Night Sweats				
Vaginal Dryness				
Urine Leakage				
Dry Skin /Wrinkles				
Dry Hair				
Fatigue				
Memory Loss				
Concentration Loss				
Hair Loss				
Loss of Libido / Orgasm				
Muscle Weakness / Loss				
Muscle and Joint Pain				
Loss of Pubic Hair				

***MALE** patients: Please check all that apply*

	NONE	MILD	MODERATE	SEVERE
Dry Skin				
Dry Hair				
Sleep Disorder				
Fatigue				
Memory Loss				
Concentration Loss				
Anxiety / Nervousness				
Irritability				
Depression				
Loss of Libido / Orgasm				
Difficulty Achieving Erection				
Difficulty Maintaining Erection				
Premature Ejaculation				
Muscle Weakness				
Muscle Loss				
Muscle and Joint Pain				
Loss of Masculinity / Confidence / Aggressiveness				

OB/GYN HISTORY (Female Patients)

Last Menstrual Period:	Age at First Onset of Period:
If still menstruating: cycle _______days	Circle if (+): Heavy Periods, Irregularity, Spotting or Pain
Are you pregnant: NO YES Are you trying for a pregnancy: NO YES	Are you breastfeeding: NO YES
Number of Pregnancies: Living children:______ Vaginal _____ C-Section _____ Abortions ____ Miscarriages____	
History of Sexual Abuse: NO YES	

PERSONAL & SOCIAL HISTORY

Occupation:		Stress Level (0-10):
Marital Status: # Living Children_______		Do you feel safe in your relationship YES NO
Use of Alcohol **NO YES**	If YES, what kind:	How many drinks / week:
Tobacco: **NO YES**	If YES, number of years total________ Cigarettes packs/day ______	Past use / Quit Date:_____________ Cigars/day ________ Chew/day________ Pipe/day______
Recreational or Street Drugs use: **NO YES**	If YES, have you ever taken street drugs with a needle:	**NO YES**
Sexually Active NO YES	Heterosexual Bi-sexual Homosexual	Contraception: Current Method:_______________________________ Past Method:________________________________
Hobbies / Interests:		

REVIEW OF SYSTEMS

Please check YES to any symptoms that you experience. For any YES answer please provide a brief description

	YES	If YES, **list doctor seen**, describe condition and how long
Fever /Chills		
Excess Fatigue		
Weight loss / gain		
Enlarged lymph nodes		
Frequent bruising		
Blurry Vision		
Ringing in Ears		
Hearing difficulty		
Mouth Sores		
Sinus Problems		
Cardiovascular:		
Chest pain at rest or exercise		
Cold hands / cold feet		
Swelling of legs		

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Gastrointestinal	**YES**	
Constipation		# bowel movement / day_______
Diarrhea		
Bloating		
Excessive Belching		
Gas / Acidity		
Blood in Stool		
Thirst: Lack of / too much		# of glasses of fluid /day_______
Genitourinary		
Pain on urination		
Cloudy / Bloody Urination		
Urinating too many times		# times per day_______
Difficulty urinating		
Loss of Urine		
Musculoskeletal: ***If YES to any of following questions, please ask for a PAIN RATING scale.***		
Do you see a chiropractor?		
Any regular body treatment /massage		
Back Pain		
Neck Pain		
Shoulder Pain		
Arm Pain		
Hip Pain		
Knee Pain		
Other Pain		
Muscle Point Tenderness (pls describe)		
Skin		
Acne		
Dry Skin		
Oily Skin		
Loss of Collagen / Firmness		
Wrinkles		
Pigmentation / Scarring		
Any History of Skin Cancer?		
Do You Wear Sunblock?		
After Sun Exposure, do you (circle):	BURN	Sometimes Burn Rarely Burn Never Burn Tan
Cellulite		
Questions on aesthetic services: Botox, Juvederm, lasers?		
Interest in Skin Care Consultation		
Emotional		
Do you see a counselor or psychiatrist		
Depression		
Anxiety		
Stress		

I have answered the above to the best of my abilities.

Patient Signature:

Mullica Hill Anti-Aging and Weight Loss Center   Patient Name:______________________ DOB:____/____/____

Nutrition Evaluation

Vegetable Intake (pls circle): <10% 20-40% 41-60% >60%	
Number of meals per day:	
Snacks per day:	What snacks & when:
Food Allergies:	
Food Dislikes:	
Food(s) you Crave	Any specific time of day /month you crave food?
Do you awaken hungry during the night? YES NO	If yes, what do you do?
Behavior Style (check only one): ____Always clam & easy going ____Usually calm & easy going ____Sometimes calm with frequent impatience	____Seldom calm and persistently driving for advancement ____Never calm and have overwhelming ambition ____Hard-driving and can never relax

	NO	YES		NO	YES	If not you, WHOM?
Partner or Spouse Overweight?			I plan my meals			
By how much_______lbs			I cook my meals			
I eat out daily			I shop for food			
I eat our _______ times / week			I use a shopping list for grocery			
I eat “fast foods” daily			Time of day I usually shop:			
I eat “fast foods” _______times / week			I use sugar substitute			
I drink cola drinks			I use butter			
I eat when I am stressed			I use margarine			
I am currently stressed			I drink coffee or tea How many cups/day:_____			
I skip meals			I eat on behalf of someone else			

If Weight Loss is an aim for you, please answer the following questions.	
Goal Weight:	In what time frame would you like to be at your goal weight:
Birth Weight:	Weight one year ago:
Highest Weight (non-pregnant) and when:	Lowest Adult Weight(>18):
Main Reason for you decision to lose weight:	
When did you begin gaining excess weight? (Give Reasons, if known)	

Previous Diets Followed	Approximate Date & Results of Weight Loss

 Patient Name:______________________ DOB:____/____/____

Typical Breakfast	Typical Lunch	Typical Dinner
__________________________	__________________________	__________________________
__________________________	__________________________	__________________________
__________________________	__________________________	__________________________
__________________________	__________________________	__________________________
Time Eaten:_____________	Time Eaten:_____________	Time Eaten:_____________
Where:_________________	Where:_________________	Where:_________________
With Whom:_____________	With Whom:_____________	With Whom:_____________

Activity Level: **(check only one):**

- ☐ Inactive: no regular physical activity with a sit-down job.
- ☐ Light activity: no organized physical activity during leisure time
- ☐ Moderate activity: occasionally involved in activities such as weekend golf, tennis jogging, swimming or cycling
- ☐ Heavy activity: consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, Swimming, cycling or active sports at least three times per week
- ☐ Vigorous activity: participation in extensive physical exercise for at least 60 minutes per session ≥ 4 times per week.

Please describe you general health goals and improvements you wish to make:__________________________________

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This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.

Additional NOTES:

Patient Signature:___________________________________