RENEW TOTAL BODY WELLNESS CENTER

CONFIDENTIAL HORMONE / ANTI-AGING HEALTH HISTORY

Today's Date: _____

NAME:_____ **Birth date :** ___/____/____ **Age:** _____

Marital Status: _____ **Level of Education**: _____
Current Occupation: _____ **Is your occupation enjoyable?** *Y / N*
Is it stressful? *Y / N* **Is it fulfilling?** *Y / N* **Hazardous Material exposure?** *Y / N*
If retired, what was your main occupation? _____
When did you retire? _____ **Are you happy in retirement?** Y / N
YOUR GOALS: *What you hope to achieve in your participation in the RENEW Wellness Program?*

_____
_____
_____

	LIST ACTIVE MEDICAL PROBLEMS	PRESCRIPTION & OTC Meds Now Taking
1.		
2.		
3.		
4.		
5.		
6.		
7.		

ALLERGIES: - DRUGS: **FOODS:**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

NUTRIENTS / SUPPLEMENTS you are taking:

_____
_____
_____
_____
_____

	LIST Hormones You ARE Taking:	LIST Hormones You HAVE Taken:
1.		
2.		
3.		
4.		
5.		
6.		
7.		

CONDITIONS: *Check <u>any other</u> conditions you have ever had in the past, & indicate what year?*

___ AIDS / HIV+ ___ Allergies / Asthma ___ Anemia ___ Alcohol / drug problem
___ Anorexia / Bulemia ___ Arthritis ___ Atrial Fibrillation ___ Anxiety / Panic Disorder
___ Back pain ___ Bleeding Disorder ___ Candida / Yeast ___ Cancer – Specify:_____

___ Chronic Fatigue ___ Crohn's Disease ___ Colitis ___ Diabetes -Type: I II
___ Depression ___ Emphysema ___ Epilepsy / Seizures ___ Fibromyalgia
___ Glaucoma ___ Goiter ___ Gout ___ Hiatal Hernia / Reflux
___ Heart Disease ___ High cholesterol ___ Irritable Bowel ___ Hypertension / High BP
___ Jaundice ___ Kidney Disorder ___ Kidney Stones ___ Liver Disease
___ Hepatitis ___ Migraines ___ Multiple Sclerosis ___ Osteoporosis
___ Pancreatitis ___ Parasites ___ Parkinson's ___ Pelvic Infl Disease
___ Pneumonia ___ Polio ___ Prostate Problem ___ Rheumatic Fever
___ Root canal ___ Sinusitis ___ Stroke / TIA ___ Suicide Attempt
___ Thyroid problem ___ TMJ ___ Tooth Abscess ___ Tuberculosis
___ Ulcers ___ Urinary Infection OTHER: _____
_____

CURRENT or RECENT SYMPTOMS: *Check any symptoms that you have noticed recently.*

___ Chest pain ___ Blood in sputum ___ Fainting / collapse ___ Leg pain w walking
___ Nose bleeds ___ Shortness of Breath ___ Swollen ankles ___ Snoring excessively
___ Abdominal Pain ___ Acid reflux ___ Black tarry stools ___ Bright blood in stool
___ Difficulty swallowing ___ Loss of appetite ___ Persistent nausea ___ Mood swings
___ Kidney pain ___ Blood in urine ___ Frequency of urination ___ Urgency of urination
___ Change in headaches ___ Double vision ___ Dizzy / spinning ___ Eye pain
___ Bone pain ___ Unusual bruising ___ Prolonged bleeding ___ Bloated
___ Excessive thirst ___ Rapid heart beat Other Symptoms:_____
___ Recent change in bowel habit _____
___ Weight loss - unexpected _____

HOSPITALIZATIONS: *Please include surgeries, illnesses, severe accidents, births, miscarriages:*

Year:	Procedure	Reason:	Outcome:

FAMILY HISTORY: *Please complete health Information about your family:*

Relation	Age:	State of health:	Age at Death:	Cause of death	Check if your blood relatives had any of the following √	Disease:	Relation to you:
Father						Arthritis / Gout	
Mother						Asthma / Hay Fever	
Brothers						Cancer: Where: ____	
						Drugs / Alcohol	
						Diabetes	
						Heart Disease	
Sisters						High Blood Pressure	
						Osteoporosis	
						Stroke	
						Cholesterol Problem	
						Thyroid	

RECENT TESTS:

If you have had any of these tests, please complete:

TEST:	Date	Reason:	Result:
Chest X Ray			
EKG			
EGD (Stomach)			
Colonoscopy			
Ultrasound			
CAT Scan			
MRI Scan			
Bone Density			
Other			

HEALTH HABITS:

***Which substances do you consume*:**

Substance	How Much?
Caffeine	**cups,cans / day**
Cigarettes	**cigs / day X yrs**
Are you interested in quitting? Y / N	
Alcohol	**Type Amount**
Drugs Y N	**What Amount**
Chew tobacco Y N	**Amount Yrs**
Nutrasweet	Servings per day:
Saccharin	Servings per day:
Splenda	Servings per day:

FOR WOMEN:

Date of 1st day of last period: _____ Birth control method: _____ Are you pregnant? Y / N

Have you ever used hormonal contraception? Y / N For How Long? _____

Any Problems ? _____

Date of last PAP test: _____ *normal / abnormal* Have you ever had an abnormal pap? Y / N

When? _____ Treatment: _____

Date of last Mammogram: _____ *normal / abnormal* Date of Menopause: _____

Review this list of symptoms/problems and check any that apply.

___ PMS (mood swings)
___ Acne
___ Uterine Fibroid
___ Fibrocystic Breasts
___ Ovarian Cysts
___ Irregular periods
___ Vaginal dryness/ irritation
___ Weight gain
___ Increased fat around hips / thighs
___ Heart palpitations
___ Painful Periods
___ Hot flashes
___ Depressed Mood
___ Vaginal Dryness / Pain
___ Loss of interest in sex
___ Leak Urine
___ Daytime Fatigue
___ Painful sex
___ Increased Body/Face Hair
___ Endometriosis
___ Thinning Skin
___ Bladder Symptoms
___ Sleep problems
___ Headaches
___ Foggy Thinking
___ Harder / Unable to Climax
___ Unusual vaginal discharge
___ Cramps / clots w periods
___ Spotting after menopause
___ Night Sweats
___ Problems w Infertility
___ Irritability

FOR MEN:

Date of last prostate exam: _____ *normal / abnormal*

Date of last PSA test: _____

Review this list of symptoms/problems and check any that apply:

___ Lowered interest in sex ___ Erections less firm ___ Difficulty in initiating urine stream
___ Getting up at night to urinate ___ Enlarged prostate ___ Can't maintain an erection
___ Slowing urinary stream ___ Urine Dribbling ___ Bladder not emptying completely

REVIEW THESE SYMPTOMS OF AGING AND CHECK ANY THAT APPLY.

Thyroid

___ Dry hair
___ Infertility
___ Headaches / Migraines
___ Losing hair
___ Constipation
___ Fluid retention
___ Crave caffeine
___ Dry coarse skin
___ Diets don't work
___ Cold hands & feet
___ Elevated cholesterol
___ Low body temperature
___ Fatigue / Exhaustion
___ Decreased memory
___ Brittle unhealthy nails
___ Unable to lose weight
___ Daytime drowsiness
___ Aches and pains
___ Elevated Cholesterol
___ Feel cold / dress more warmly
___ Foggy / spacey mind
___ Depression / Anxiety
___ Low ambition / motivation
___ Decreased concentration
___ Fibromyalgia / Chronic fatigue

Cardio-Respiratory:

___ Decreased ability and desire for exercise
___ Palpitations
___ Decreased stamina
___ Decreased endurance
___ Run out of breath sooner
___ Easily exhausted with exercise

Skin / Integumentary:

___ Dry skin
___ Thin Lips
___ Graying hair
___ Skin blemishes
___ Thin brittle nails
___ Tendency to bruising
___ Thinned skin –hands, face, arms
___ Thinning hair – scalp, armpits, legs
___ Wrinkling skin – face, neck, hands & arms
___ Sagging skin – under eyes, arms, face, breasts

Adrenal:

___ Palpitations
___ Salt craving
___ Sugar craving
___ Panic attacks / ___ Anxiety
___ Depression
___ Easily frustrated
___ Excessive hunger
___ Prone to infection / ___ Chronic illness
___ Low blood pressure
___ Poor stress tolerance
___ Low back pain (SI joints)
___ Light headed on standing up
___ Racing mind prevents sleep
___ Autoimmune illness
___ Aches and Pains
___ Elevated Triglycerides
___ Blood sugar imbalance
___ Evening Fatigue

Metabolism:

___ Can not skip meals
___ High blood pressure
___ Headache w missed meal
___ Cravings for sugar & carbs
___ High cholesterol / triglyceride
___ Increased fat around abdomen
___ Prone to inflammation and bursitis
___ Periods of low energy relieved w food
___ Shaky / weak episodes – Eating helps
___ Jittery / irritable episodes – Eating helps
___ Alternating between high and low moods
___ Alternating between sluggish and high energy

Neuro-cognitive:

___ Loss of esteem
___ Feeling hopeless
___ Feeling defeated
___ Loss of confidence
___ Vision deteriorating
___ Hearing deteriorating
___ Memory deteriorating
___ Sense of powerlessness
___ Decreased sense of well being

Gastrointestinal:

___ Feel full faster
___ Slower digestion
___ Fullness after meals
___ Eat less / smaller meals
___ Indigestion / Hyperacidity
___ Burping or belching after meals
___ Decreased sense of taste / smell

Muscles/Joints:

___ Osteoporosis
___ Aches and Pains
___ Loss of strength
___ Body & joints stiff
___ Balance deteriorating
___ Coordination deteriorating
___ Thinning muscles – buttocks, arms, legs

DIET: Are you on any specific diet? *(Please specify:*_____
Has this been successful? Y / N
List which diet(s) have been effective in the past: _____
How is your current weight - Happy? Y / N Weight Goal: _____

STRESS:
Rate your current stress level: *Extreme; High; Medium; Low (Please circle)*
How long has it been like this? _____
You expect this to last a *short medium long* period of time. *(please circle)*
Is your stress: at Home at Work
Do you have a solution? Y / N
Do you need help? Y / N

EXERCISE: *Please circle which you do.*
Aerobic Weights Walking Other:_____
How long are your workout sessions? _____ How many days /week? _____

SLEEP: *Please check the symptoms that you notice.*
___ Trouble getting to sleep – racing mind
___ Nightime awakening(s) – How many? _____
___ Sleep not as restful / Wake up not rested
___ Wake up through night feeling like you are choking or having a smothered sensation
___ Your partner has noticed very heavy snoring during sleep
___ Your partner has noticed that you stop breathing through the night with heavy snoring
___ Daytime drowsiness or sleepiness especially with periods of inactivity
___ Toss and turn through night / wake frequently through the night

Take a moment to reflect on your response to the following question:
On a scale of 0 – 5 (5 being the strongest response), circle your response:

How important is it to you, and how committed are you to a wellness program? 0 1 2 3 4 5