Metabolic Anti-Aging Center of Louisiana

Demographic Information

Name (last, first, MI)			Social Security No.		Birth Date
Age	Sex	Marital Status M / S / D	Home Phone ( )	Work Phone ( )	
Home Address (street, city, state and zip code)			Cell Phone ( )		
			Email Address		
Employer			Job Title		
Emergency Contact (Name)		Contact (Phone)		Who referred you?	
Personal Physician (Name and Address) Office Phone:				Preferred Pharmacy Name/Phone	

History

This section is for the purpose of learning more about your health history. Please read and answer all of the following questions to the best of your knowledge.

Reason for Consultation

What health concern and symptoms brings you to the clinic? _____

Patient Name: _____ Date of Birth:_____

What would you most like to achieve with this health consultation? _____

_____

_____

_____

_____

_____

_____

_____

Are you currently under the care of a physician or health professional for a medical/health condition? ❍ Yes ❍ No If yes, please list condition(s): _____

_____

_____

_____

_____

Past Medical History

Please check any medical conditions or health problems that you currently have or have had in the past?

Headaches (Migraines, other)	❍ yes ❍ no	Heart Disease	❍ yes ❍ no
Seizures Disorder	❍ yes ❍ no	Chest Pain	❍ yes ❍ no
Recurrent sinus infections	❍ yes ❍ no	Irregular Heart Beat	❍ yes ❍ no
Seasonal allergies	❍ yes ❍ no	High Blood Pressure	❍ yes ❍ no
Psychiatric or Emotional Illness	❍ yes ❍ no	Blood Clotting problems	❍ yes ❍ no
Depression	❍ yes ❍ no	Bleeding disorder	❍ yes ❍ no
Anxiety or excessive stress	❍ yes ❍ no	Stroke/vascular disease	❍ yes ❍ no
Asthma	❍ yes ❍ no	Constipation/diarrhea	❍ yes ❍ no
Chronic bronchitis	❍ yes ❍ no	Hepatitis/Liver disease	❍ yes ❍ no
Lung or breathing problems	❍ yes ❍ no	Kidney disease	❍ yes ❍ no
Chronic Indigestion	❍ yes ❍ no	Menstrual disorders	❍ yes ❍ no
Stomach Ulcers	❍ yes ❍ no	Reproductive problems	❍ yes ❍ no
Intestinal Disease	❍ yes ❍ no	Prostate problems	❍ yes ❍ no
Skin problems/dermatitis	❍ yes ❍ no	Sexual/Libido problems	❍ yes ❍ no
Back Pain or Sciatica	❍ yes ❍ no	Tendonitis	❍ yes ❍ no
Herniated Disc	❍ yes ❍ no	Chronic pain problems	❍ yes ❍ no
Neck pain	❍ yes ❍ no	Shoulder problems	❍ yes ❍ no
Chronic Muscle or Joint Pain	❍ yes ❍ no	Osteoarthritis	❍ yes ❍ no
Carpal Tunnel Syndrome	❍ yes ❍ no	Rheumatoid Arthritis	❍ yes ❍ no
Fibromyalgia	❍ yes ❍ no	Artificial joint/implants	❍ yes ❍ no
Diabetes	❍ yes ❍ no	Cancer	❍ yes ❍ no
Thyroid disease	❍ yes ❍ no	Psoriasis or eczema	❍ yes ❍ no
Osteoporosis/Osteopenia	❍ yes ❍ no		

List any additional health problems not listed above: _____

_____

_____

_____

Patient Name: _____ Date of Birth:_____

List any surgeries/operations you have had, and when: _____

_____

_____

_____

List any medications you are currently taking (or have taken in the recent past)

Medication Name	**Date Started**	**Date Stopped**	**Dosage** ***(amt/# daily)***

(If any additional medications please attached a separate page list the above info)

Nutritional supplements, vitamins, herbs, homeopathic remedies taken: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Medication Allergies:

_____

_____

_____

Environmental/Food Allergies: _____

_____

_____

Preventive Tests:	***Month/Year of last test***	***Test Results (if known)***
Cholesterol	_____	_____
Bone density	_____	_____
Colonoscopy	_____	_____

Patient Name: _____ Date of Birth:_____

Exercise stress test _____ _____

Family History *(Write the relationship of the relative(s) with the disease on the adjacent lines)*

Heart Disease ❍ yes ❍ no _____

High Blood Pressure ❍ yes ❍ no _____

Diabetes ❍ yes ❍ no _____

Arthritis ❍ yes ❍ no _____

Skin disorders ❍ yes ❍ no _____

Breast Cancer ❍ yes ❍ no _____

Uterine/Ovarian Cancer ❍ yes ❍ no _____

Prostate Cancer ❍ yes ❍ no _____

Colon Cancer ❍ yes ❍ no _____

Other Cancer ❍ yes ❍ no _____

List any other disease/condition in the family and relationship? _____

_____

_____

WOMEN

ARE YOU PREGNANT? ❍ yes ❍ no First day of last menstrual cycle _____

Date of last pap/pelvic/breast exam _____ Results: ❍ normal ❍ abnormal

Date of last mammogram _____ Results: ❍ normal ❍ abnormal

Do you perform monthly self breast exams ❍ yes ❍ no

Are you currently taking or have you in the past taken hormones or oral contraceptives ❍ yes ❍ no

Patient Name: _____ Date of Birth:_____

If yes, please list all hormones and oral contraceptives you have taken and when _____

_____

_____

_____

_____

_____

Have you ever had any problems or concerns about taking hormone replacement therapy?

❍ yes ❍ no

If yes please list problem: _____

_____

How many pregnancies have you had? _ How many children?

_____

Have you had a hysterectomy? ❍ yes ❍ no If yes, were your ovaries removed? ❍ yes ❍ no

Have you had any menstrual irregularities? ❍ yes ❍ no (*if yes explain*) _____

_____

_____

_____

Has your abdominal girth and weight been increasing? ❍ yes ❍ no

MEN

Date of last prostate exam: _____

Are you concerned with loss of muscle mass, tone, or strength? ❍ yes ❍ no

Have you had problems with urination *(decreased stream, frequent night urination)* ❍ yes ❍ no

Do you perform periodic testicular self examination? ❍ yes ❍ no

Has your abdominal girth and weight been increasing? ❍ yes ❍ no

Social History and Personal Health Habits

- **General** **(*Check all that apply)***

  My health is ❍ *excellent* ❍ *good* ❍ *fair* ❍ *poor*.

  My physical fitness is ❍ *excellent* ❍ *good* ❍ *fair* ❍ *poor*

  ❍ I am under a lot of stress ❍ I am fatigued all the time ❍ I am having difficulty dealing with stress ❍ I practice meditation or other relaxation techniques ❍ I am often sad and blue

- **Dietary Habits**

  ❍ No special diet habits ❍ Avoids red meat ❍ Minimizes fat ❍ Minimizes Carbs ❍ Vegetarian

  ❍ Emphasize fruits, grains and vegetables ❍ I try to eat a healthy diet

  ❍ I do not eat dairy/cheese ❍ I commonly eat at fast food restaurants

Patient Name: _____ Date of Birth:_____

I commonly consume: ❍ Coffee ❍ Regular soft drinks ❍ Diet soda ❍ Candy/chocolate ❍ Chips/crackers

- **Exercise Habits**

  ❍ No special exercise habits ❍ I routinely exercise ____hr(s) ____X/week

  ❍ Aerobic exercise (jog/walk/treadmill) ❍ Lift weights ❍ Swim

  ❍ Stretch/Yoga/Tai Chi/Chi Gong

  Other_____

- **Tobacco Use**

  ❍ I never smoked cigarettes or chewed tobacco

  ❍ I now smoke _____ packs of cigarettes per day. I have smoked for _____years

  ❍ I quit smoking in _____(mo/yr). I smoked _____packs/day for _____ years

  ❍ I smoke cigars/pipe

- **Alcohol Use**

  ❍ I never drink alcohol ❍ I drink occasionally or socially

  ❍ I regularly drink: ❍ 1-2 drinks/day ❍ more than 2 drinks/day ❍ more than 4 drinks/day

- **Hobbies/Sports/Recreation**

  List routine hobbies/sports/recreational activities: _____

  _____

  _____

_____ _____

_____

Patient Signature **Date**

A 24 hour notice of cancellation is required. If your cancellation is less than 24 hours or you do not show for your appointment a rescheduling fee will apply before for your next appointment. This is for the consideration of our patients that are waiting for a sooner appointment and allows us the necessary time to contact them with the sooner appointment availability. We thank you for understanding regarding this policy that has proven to be very successful in meeting our patient's medical needs.

Practitioner comments on above: _____

_____

_____

_____

_____

Patient Name: _____ Date of Birth:_____