CONSULTATION FORM

Patient Information

Name **M** **Last Name**

Date of Birth (mm/dd/yyyy)

Street Address **City** **State, Zip Code**

Home Phone **Cell Phone** **Fax**

Email Address

Height **Current Weight** **Desired Weight**

Goals for Age Management Medicine Consultation

Current Medical Conditions

How would you rate your health compared to that of individuals your own age?

Excellent Good Average Fair Poor

Overall, how satisfied are you with the current state of your health?

Very satisfied, want to maintain my health

Satisfied, but could do better

Dissatisfied, limited by my current health

Very dissatisfied, need to improve current health

Please go over any details pertaining to the answer above.

Current Nutrition/Herbal Supplements (please be as specific as possible)

Female Hormone Symptom Profile

Please check any of the following symptoms which currently or periodically affect you.

Aches and Pains
Acne
Amenorrhea
Anxiety
Arthritis / Stiffness
Bladder Symptoms
Blood Pressure - Low
Blood Pressure - High
Body Temperature Low (Below 98 Degrees)
Breakthrough Bleeding
Breasts Sagging / Less Fullness
Breast Tenderness
Breast Size Increased
Cold Intolerance
Cold Hands and Feet
Constipation
Painful Menses
Decreased Libido
Decreased Sense of Sexuality
Decreased Sexual Arousability
Depression
Diarrhea
Drowsiness
Dry Skin and/or Hair
Endometriosis, Fibroids, Adenomyosis
Fatigue
Fibrocystic Breasts
Foggy Thinking
Food Cravings
Forgetfulness
Hair Loss - Scalp
Hair Loss - Pubic, Armpit and Body
Harder to Reach Climax
Headaches
Heart Palpitation
Heat Intolerance
Heavy / Irregular Menses
Hot Flashes
Insomnia / Sleep Disturbances
Irritability
Mood Swings
Muscle Flabbiness / Decreased Size
Muscle Weakness
Nail Abnormality (Thick, Brittle, Ridged)
Night Sweats
Nipple Tenderness
Osteoporosis
PMS
Sensitive to Temperature Swings
Sweating
Temperature Swings
Vaginal Dryness
Water Retention / Bloating
Weakness
Weight Gain
Weight Loss
Wrinkles