

Rejuvenation

The Center for Healthy Living

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Patient Demographics.

Today's Date:

Name:

Gender: M F

DOB:

Age:

Physical Address:

City:

State:

Zip:

Mailing Address:

City:

State:

Zip:

Hm#:

Wk#:

Cell #:

Social Security#:

E-mail Address:

Whom may we thank for your referral?

Comments:

MEDICAL HISTORY

Today's Date:

Name:

Gender: M

DOB:

Age:

Occupation:

Height:

Weight:

ENERGY LEVEL

How would you rate your energy level on a scale from 1-10, 1 means extremely low and 10 means full of energy _____ / 10

Do you feel like you are living in slow motion?

Yes No

Do you feel a constant (background) tiredness or fatigue?

Yes No

Are you easily exhausted with physical activity?

Yes No

Do you have difficulty handling stress?

Yes No

Do you have energy swings? Yes No

Do you feel you should have more energy?

Yes No

How long have you been feeling this way? _____ Year(s)

Are you run down around 4:00 p.m.?

Yes No

Do you eat something sweet when you feel this way? Yes No

Do you feel better at these times after you eat something sweet? Yes No

Do you wake up tired? Yes No

Is it difficult for you to stay up late (after midnight)? Yes No

Do you get very tired in the evening or early night? Yes No

Do you have difficulty recovering after having stayed up late night? Yes No

Do you feel more tired when you are at rest than when you are active? Yes No

WEIGHT CONTROL

Have you had any significant weight gain?

Yes No

How many pounds? _____ lbs.

What year did it start? _____

Do you feel you put on weight easily? Yes No

Do you have difficulty losing weight? Yes No

How long have you had this problem?

_____ Year(s)

Do you put on weight around your waist?

Yes No

Do you put on weight around your thighs and buttocks? Yes No

Do you have a flabby abdomen or a "spare tire"? Yes No

Are you pear-shaped? Yes No

Is your upper abdomen distended? Yes No

Is your lower abdomen distended? Yes No

Do you suffer from constipation? Yes No

TEMPERATURE SENSITIVITY

Are you sensitive to cold? Yes No

Do your hands and feet feel cold? Yes No

How long have you experienced this?

_____ Year(s).

Do you get chills easily? Yes No

Do the palms of your hands or feet perspire unusually? Yes No

How long have you experienced this? _____ Year(s).

Do you have decreased perspiration?

Yes No

How long have you experienced this? _____ Year(s).

MOOD AND MEMORY

Are you ever anxious, nervous or irritable?
 Yes No
Do you lose self-control? Yes No Do you
have difficulty making decisions or setting goals
Yes No
If yes, how long have you been this way?
Do you tend to isolate yourself? Yes No
Are you less self-confident now?
 Yes No
Do you ever feel discouraged, blue or
depressed?
 Yes No
If yes, what percentage of the time? _____%

HAIR

Do you have fine hair or coarse hair?
_____ Fine _____ Coarse
How long have you had this type of hair?
_____ Year(s)
Are your eyebrows or eyelashes thinning?
 Yes No
Do you have hair loss or thinning of hair on your
head?
 Yes No
Do you have dry, thick, brittle hair?
 Yes No
Does your hair grow slowly?
 Yes No

SKIN

Do you have fine lines or crow's feet at the side of
the eyes?
 Yes No
Do you have lines on your forehead?
 Yes No
Does the skin of your face look puffy, pale or
doughy?
 Yes No
Is the skin on the back of your hands thin?
 Yes No
Do you have lines on the side of your mouth?
 Yes No
Do you have dry skin?
 Yes No
If yes, since when?
_____ Year(s).

Are you intolerant of noise? Yes No
Do small things set you off? Yes No
Have you noticed a decrease in mental
sharpness? Yes No
Do you have a poor short-term memory?
 Yes No
Do you have trouble concentrating? Yes No
How long have you felt this way? _____
Year(s).
Do you or have you ever taken antidepressants?
 Yes No
If yes, which ones? _____
If yes, between what ages? _____

Do you have less armpit hair?
 Yes No
Do you have less pubic hair?
 Yes No
Is your hair graying?
 Yes No
Is your hairline receding?
 Yes No
Is it receding on the sides of the forehead?
 Yes No
Are you losing your hair on top of your head?
 Yes No

Do you have rosacea (redness on the nose and
cheeks)?
 Yes No
Do you have eczema, psoriasis or other rashes?
 Yes No
Do you have age spots?
 Yes No
Do you have thin, vertical wrinkles above your
lips?
 Yes No
Do your cheeks sag?
 Yes No
Are your nails brittle?
 Yes No
Do you have acne?
 Yes No

EYES

Do you have swelling or puffiness around your eyes or your face in the morning?

- Yes No

Do you have swollen eyelids in the morning?

- Yes No

Do you have dark circles under your eyes?

- Yes No

How long have you had any of these problems?

_____ Year(s).

Does the swelling occur often?

- Yes No

Do your eyes feel dry?

- Yes No

Do you see as brightly as before?

- Yes No

Do you wear corrective lenses of any sort?

- Yes No

MUSCULO-SKELETAL

Do you feel your muscles are flabby or slack?

- Yes No

Do your joints get stiff in the morning?

- Yes No

Do you have arthritis?

- Yes No

If yes, where? _____

Do you have osteoarthritis of the hips?

- Yes No

Do you have muscular pain?

- Yes No

If yes, where? _____

Do you have bone loss or osteoporosis?

- Yes No

Do you suffer from low back pain?

- Yes No

Are your exercise work-outs less effective?

- Yes No

SLEEP

How many hours do you sleep each night, on average? _____

Do you feel you need a lot of sleep?

- Yes No

Do you have trouble falling asleep at night?

- Yes No

Is your mind filled with thoughts as you are trying to go to sleep?

- Yes No

Do you wake up during the night?

- Yes No

Can you go back to sleep easily during the night?

- Yes No

Do you have nervous, anxious or restless sleep?

- Yes No

Do you have a tendency to go to bed late and wake up late in the morning?

- Yes No

Do you have difficulty waking up in the morning?

- Yes No

Do you wake up too early with a heavy head in the morning?

- Yes No

When you get up in the morning, are you rested?

- Yes No

Do you take something to help you sleep?

- Yes No

If yes, what do you use?

SOCIAL HISTORY

Do you use tobacco? Yes No

How often and how much?

Do you consume alcohol? Yes No

Do you use caffeine? Yes No

Personal History

Do you feel less confident and more hesitant?

Yes No

Does your beard grow more slowly now?

Yes No

Are your breasts getting fatty?

Yes No

Do you have hot flashes and sweats?

Yes No

Do you lack sexual desire?

Yes No

Have you lost attraction towards your partner?

Yes No

Do you feel like making love less often than you used to?

Yes No

Is sexual intercourse as pleasurable as it used to be?

Yes No

Do you feel your sexual performance is poorer than it used to be?

Yes No

Does your penis seem less sensitive?

Yes No

Has your penis changed in dimension?

Yes No

Are you able to obtain an erection?

Yes No

Are you able to maintain an erection?

Yes No

Are your erections firm enough?

Yes No

Are you able to achieve orgasm?

Yes No

Have you or do you use medication for erectile dysfunction, such as Viagra?

Yes No

Medical Conditions/Diseases/Testing:

Do you exercise at least once a week?

Yes

No

How do you rate your energy level?

High

Fairly High Low Poor

How do you rate your stress level?

High

Tolerable Good Ideal

How often do you exercise every week?

Once

Twice Three times or more

Overall how would you rate your health?

Excellent

Good Fair Poor

What type of exercise do you do?

Aerobic

Anaerobic /Strengthening Both

Do you have any medical conditions? Please check all that apply to you.

Cancer

Headaches/migraines

Heart disease

High Blood Pressure

High Cholesterol or lipids

Hormonal Related Issues

Thyroid disease

Ulcers

Depression

Lung condition /Asthma

Blood Clotting Problems

Arthritis or joint problems

Diabetes

Immune system disorders

Others: _____

Epilepsy

Have you ever been diagnosed with a thyroid disorder? Yes No

If yes, year diagnosed. _____

Are you Hyperthyroid (high) or Hypothyroid (low)? Hyperthyroid Hypothyroid

Do you or have you ever taken thyroid medication? Yes No

If yes, how long? _____

If yes, what brand and dose?

_____mg _____how often?

If not at this time, what year did you quit taking medication?

Past Surgical History	Surgery	Year	Surgeon

Past Diagnostic Investigation.	Year	Test	Result

Current Prescription Medication(s):

Medication Name	Strength	Date Started	How often per day

List Hormones Previously Taken:	Date Started	Date Stopped	Reason

Over-the-counter (OTC) meds: Please check all products that you use occasionally or regularly.

- | | |
|--|--|
| <input type="checkbox"/> Acetaminophen (example: Tylenol) | <input type="checkbox"/> Diet aids/ weight loss products |
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Ibuprofen (example: Motrin®) |
| <input type="checkbox"/> Antidiarrheals | <input type="checkbox"/> Ketoprofen |
| <input type="checkbox"/> Antihistamine product (| <input type="checkbox"/> Naproxen (example: Aleve®) |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Others: |
| <input type="checkbox"/> Combination product (cough + cold reliever) | <input type="checkbox"/> Pain reliever |
| <input type="checkbox"/> Cough suppressant | <input type="checkbox"/> Sleep aids |

Nutritional/Natural Supplements: Please identify and check the products you are using:

- Enzymes
- Herbs
- Minerals
- Nutrition/protein supplements
- Others
- Vitamins

Allergies: Please check all that apply.

- No known allergies
- Aspirin
- Codeine
- Dye allergies
- Food allergies
- Morphine
- Nitrate allergies
- Penicillin
- Pet allergies
- Seasonal(pollen)allergies
- Sulfa drug
- Others: _____

Please describe the allergic reaction you experienced and when it occurred? _____

FAMILY HISTORY

Do you have family history of any of the following?(Relation with the family member)

- | | | | | |
|--------------------|-----------------------------|------------------------------|------------------|-------|
| Breast Cancer | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Family member(s) | _____ |
| Depression | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Family member(s) | _____ |
| Diabetes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Family member(s) | _____ |
| Fibrocystic breast | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Family member(s) | _____ |
| Heart Disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Family member(s) | _____ |
| Obesity | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Family member(s) | _____ |
| Osteoporosis | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Family member(s) | _____ |
| Ovarian Cancer | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Family member(s) | _____ |
| Prostate Cancer | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Family member(s) | _____ |
| Skin Conditions | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Family member(s) | _____ |
| Uterine Cancer | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Family member(s) | _____ |

OTHERS:--

Your Physicians:

Doctors' Names: Specialty: Address: Phone:
