

Rejuvenation

The Center for Healthy Living

David. W. Powell MD

hormonehealth@yahoo.com

720 South Mason Road
Katy Texas 77450
Ph:281-392-6550
Fax: 281-392-5008

8191 S/W Freeway #101
Houston Texas 77074
Ph 713-772-7887
Fax 713-772-7997

Patient Demographics

Today's Date:

Name:

Gender: Female

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: Female

DOB:

Age:

Occupation:

Height:

Weight:

Chief Complaints

Anxiety? Yes No

Are you growing facial hair? Yes No

Bloating? Yes No

Breast tenderness? Yes No

Cravings? Yes No

Crying? Yes No

Depression? Yes No

Fatigue? Yes No

Fluid retention? Yes No

Forgetfulness? Yes No

Headaches? Yes No

Heart palpitations? Yes No

Hot flashes? Yes No

Insomnia? Yes No

Irritability? Yes No

Menstrual Cramps? Yes No

Mood Swings? Yes No

Night sweats? Yes No

Weight Gain? Yes No

Have any of the above symptoms caused you to be unable to carryout your daily responsibilities?

Yes No

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

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? _____ %

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

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? _____

How long have you experienced this? _____
Year(s).
Do you have decreased perspiration?
 Yes No
How long have you experienced this? _____
Year(s)

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

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

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

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

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?

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

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 MENSTRUAL PERIODS

At what age did your menstrual periods start?

_____ years old.

Do you still have menstrual periods? Yes No

Do your menstrual periods occur at about the same time each month? Yes No

If no, what is the shortest number of days between periods?

_____ days.

If no, what is the longest number of days between periods?

_____ days.

How long have your menstrual cycles been irregular _____ months to _____ years.

Were your menstrual cycles ever regular? Yes

No

If yes, when?

How many days do your periods last?

_____ days.

Are your periods heavier or lighter than in the past?

Heavier Lighter Same

If so, when did they change?

_____/_____ (month/year)

Do you have bleeding that occurs between your normal periods? Yes No

What was the date of your last normal menstrual cycle? _____

PREGNANCY

How many pregnancies have you had?

How many live births have you had?

How many miscarriages have you had?

How many children do you have?

What is the date of your last child's birth?

How old were you at the time of your last delivery? _____ years old.

Did you have difficulty becoming pregnant?

Yes No

Did you ever receive infertility treatment?

Yes No

If yes, what kind? _____

BIRTH CONTROL

Have you had a tubal ligation?

Yes No

If yes, when? _____ / _____ (month/year)

Have you ever used birth control pills?

Yes No

If yes, for how long?

_____ / _____ (month(s)/year(s))

Have you discontinued taking birth control pills?

Yes No

When did you discontinue taking birth control pills?

_____ / _____ (month/year)

Breast

Do you feel your breasts are droopy?

Yes No

Are your breasts swollen, tender or painful before your menstrual periods?

Yes No

Do you have fibrocystic breast disease?

Yes No

If so, for how long? _____

Have you had an abnormal discharge from your breasts? Yes No

If yes, what color? _____

If yes, for how long? _____

Have you had lumps in your breasts?

Yes No

BLADDER / OVARIES/ VAGINA/ UTERUS

Do you urinate frequently?

Yes No

Do you get recurrent bladder infections?

Frequently Occasionally Rare

Do you lose urine when you cough or sneeze

Yes No

Have you had ovarian cysts?

Yes No

If yes, how many times?

Have you ever had endometriosis?

Yes No

If yes, for how long?

_____ / _____ (month(s)/year(s))

Are you currently using an IUD?

Yes No

Have you ever taken Depo-Provera?

Yes No

Are you currently taking estrogen?

Yes No

Are you currently taking progesterone?

Yes No

Are you currently taking any other hormones?

Yes No

If yes, which one(s)?

Have you ever had a breast biopsy?

Yes No

If yes, how many times? _____

If yes, when? _____

Have you had your breast(s) aspirated?

Yes No

If yes, how many times? _____

Do you have breast implants?

Yes No

If yes, when was the surgery performed?

Are they saline or silicone?

Saline Silicone

Have you ever had uterine fibroids?

Yes No

If yes, for how long?

_____ / _____ (month(s)/year(s))

Do you have vaginal dryness?

Yes No

If yes, for how long?

_____ / _____ (month(s)/year(s))

Have you had a hysterectomy?

Yes No Date of surgery: _____

Were your ovaries removed?

Yes No

SEX

Do you have a decrease in sexual desire?

- Yes No

If yes, for how long?

_____/_____(month(s)/year(s))

Do you find it more difficult to achieve orgasm?

- Yes No

Are you able to achieve orgasm?

- 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

Have you ever had pain during intercourse?

- Yes No

Have you ever had pain after intercourse?

- Yes No

Is this pain due to vaginal dryness?

- Yes No

Overall how would you rate your health?

- Excellent Good Fair Poor

How do you rate your energy level?

- High Fairly High Low Poor

How do you rate your stress level?

- High Tolerable Good Ideal

Do you exercise at least once a week?

- Yes No

How often do you exercise every week?

- Once Twice Three times or more

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 Diagnostic Investigation.

- | | | | | | |
|--------------|-----------------------------|------------------------------|-------------|---------------------------------|-----------------------------------|
| Mammography | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Date: _____ | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| PAP Smear | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Date: _____ | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |
| Bone density | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Date: _____ | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal |

Current Prescription Medication(s):

Medication Name	Strength	Date Started	How often	per day
-----------------	----------	--------------	-----------	---------

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

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

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

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

List Hormones Previously Taken: Date Started Date Stopped Reason

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? _____

Past Surgical History Surgery Year Surgeon

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:
Phone:

Specialty:

Address:
