



# 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.		

<b>ALLERGIES: - DRUGS:</b>	<b>FOODS:</b>
_____	_____
_____	_____
_____	_____
_____	_____

**NUTRIENTS / SUPPLEMENTS you are taking:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> AIDS / HIV+        | <input type="checkbox"/> Allergies / Asthma | <input type="checkbox"/> Anemia              | <input type="checkbox"/> Alcohol / drug problem   |
| <input type="checkbox"/> Anorexia / Bulimia | <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Anxiety / Panic Disorder |
| <input type="checkbox"/> Back pain          | <input type="checkbox"/> Bleeding Disorder  | <input type="checkbox"/> Candida / Yeast     | <input type="checkbox"/> Cancer – Specify: _____  |

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

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

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

<u>Relation</u>	<u>Age:</u>	<u>State of health:</u>	<u>Age at Death:</u>	<u>Cause of death</u>	<u>Check if your blood relatives had any of the following</u>	
					<u>Disease:</u>	<u>Relation to you:</u>
Father					<input type="checkbox"/> Arthritis / Gout	
Mother					<input type="checkbox"/> Asthma / Hay Fever	
Brothers					<input type="checkbox"/> Cancer: Where: _____	
					<input type="checkbox"/> Drugs / Alcohol	
					<input type="checkbox"/> Diabetes	
					<input type="checkbox"/> Heart Disease	
Sisters					<input type="checkbox"/> High Blood Pressure	
					<input type="checkbox"/> Osteoporosis	
					<input type="checkbox"/> Stroke	
					<input type="checkbox"/> Cholesterol Problem	
					<input type="checkbox"/> 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
<b>Are you interested in quitting? Y / N</b>	
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 1<sup>st</sup> 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.

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

**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:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Lowered interest in sex        | <input type="checkbox"/> Erections less firm | <input type="checkbox"/> Difficulty in initiating urine stream |
| <input type="checkbox"/> Getting up at night to urinate | <input type="checkbox"/> Enlarged prostate   | <input type="checkbox"/> Can't maintain an erection            |
| <input type="checkbox"/> Slowing urinary stream         | <input type="checkbox"/> Urine Dribbling     | <input type="checkbox"/> 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
- Nighttime 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