METABOLIC
CENTER *for* WELLNESS

Name_____ DOB _____

PERSONAL HISTORY

MEDICAL PROBLEMS Do you have or have you ever been diagnosed with the following?

- ❑ Adrenal gland disease
- ❑ Arthritis
- ❑ Asthma
- ❑ Cancer
- ❑ Diabetes
- ❑ Emphysema/COPD
- ❑ Gall bladder disease
- ❑ Gout
- ❑ Heart disease
- ❑ High Blood Pressure
- ❑ High cholesterol
- ❑ Hives or eczema
- ❑ Kidney disease
- ❑ Migraine headaches
- ❑ Osteoporosis
- ❑ Pituitary disease
- ❑ Psychiatric disorder
- ❑ Reflux
- ❑ Seizures
- ❑ Stroke
- ❑ Thyroid disease

Other_____

CURRENT SYMPTOMS Are you currently experiencing any of the following?

- ❑ Abdominal pain
- ❑ Anxiety or depression
- ❑ Bleeding or lymph node issue
- ❑ Blood in stool
- ❑ Blood in urine
- ❑ Change in voice
- ❑ Chest pain
- ❑ Constipation
- ❑ Cough or wheeze
- ❑ Dental or gum problems
- ❑ Diarrhea
- ❑ Fatigue
- ❑ Fevers or night sweats
- ❑ Headaches
- ❑ Increased thirst
- ❑ Joint pains
- ❑ Muscle pains
- ❑ Nausea or vomiting
- ❑ Numbness or tingling
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Sinus issues
- ❑ Skin rashes or hives
- ❑ Trouble or pain swallowing
- ❑ Urination: more frequent
- ❑ Urination: painful
- ❑ Vision: blurred
- ❑ Vision: decreased
- ❑ Weight gain
- ❑ Weight loss

WOMEN

Menstrual cycle (periods)

Age at first period _____
Date of last period _____

Regular? ❑ Y ❑ N
Heavy or painful? ❑ Y ❑ N

Decreased libido ❑ Y ❑ N
Sexual dysfunction ❑ Y ❑ N
Breast discharge ❑ Y ❑ N

MEN

Decreased libido ❑ Y ❑ N
Erectile dysfunction ❑ Y ❑ N
Prostate disease ❑ Y ❑ N

Other

Name_____ DOB _____

SURGICAL HISTORY Please list any surgeries you have had

Surgery _____ Date _____

Surgery _____ Date _____

Surgery _____ Date _____

Surgery _____ Date _____

Surgery _____ Date _____

ALLERGIES Please list

_____ _____

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY

Are you employed? ❑ Y ❑ N
If YES, what is your occupation? _____

Do you smoke tobacco? ❑ Y ❑ N
If YES, how much and how often? _____

Do you drink alcohol? ❑ Y ❑ N
If YES, how much and how often? _____

FAMILY HISTORY List any family members who have the following conditions.

❑ Y ❑ N Cancer _____

❑ Y ❑ N Diabetes _____

❑ Y ❑ N Heart disease _____

❑ Y ❑ N High blood pressure _____

❑ Y ❑ N High cholesterol _____

❑ Y ❑ N Kidney disease _____

❑ Y ❑ N Thyroid disease _____

Other_____

Name_____ DOB _____

MEDICATION Please list all medications you take and their doses. Please include any insulin or over-the-counter supplements.

Medication _____ Dose _____ How often? _____

Medication _____ Dose _____ How often? _____

Medication _____ Dose _____ How often? _____

Medication _____ Dose _____ How often? _____

Medication _____ Dose _____ How often? _____

Medication _____ Dose _____ How often? _____

WHAT IS THE MAIN REASON OR CONCERN FOR YOUR VISIT TODAY?