Tampa Rejuvenation
Weight Loss | Fitness | Nutrition | Hormone Therapy

Health Questionnaire

Medical Health Questionnaire

Date

Please answer the following questions. Some may not apply and may be left unanswered. Please be as thorough and specific as possible.

Personal Information

Full Name
Date of Birth
Address | City | State | ZIP
Home Phone | Work Phone | Mobile Phone
E-mail | Cell Phone Carrier | How did you hear about us?

Preferred method of contact: ☐ E-mail ☐ Cell Phone ☐ Text Message ☐ Does not matter

List two people you know who could benefit from our service (if they join receive a $50 gift card to use at Tampa Rejuvenation):

	Name:	Relationship:	Phone Number:
1.			
2.			

What are your main concerns you would like to address during your consultation?

Primary Care Physician (PCP) | Phone

Lifestyle Factors

WORK Occupation
How many hours per week do you work?

HOME If you have kids, list their names, ages, and genders here
Do any of your family members have special needs? If so, who? Describe their situation.
Marital Satus:

PHYSICAL ACTIVITY Type
Duration Hours / Minutes
Intensity ☐ Low ☐ Moderate ☐ High
Frequency (times/week)
Are you consistent? ☐ Yes ☐ No
Regardless of your exercise program, are you sedentary for most of the day? ☐ Yes ☐ No

SLEEP Average hours of sleep per night
Do you awake feeling well rested? ☐ Yes ☐ No
Do you often have trouble falling asleep? ☐ Yes ☐ No
Do you have sleep apnea? ☐ Yes ☐ No ☐ Unsure
If you have sleep apnea, is it being treated? ☐ Yes ☐ No
Do you wake up at night? ☐ Yes ☐ No
How many times?
If you know why, please explain.

STRESS Do you have an unusually high amount of stress in your life? ☐ Yes ☐ No ☐ Sometimes
Do you have appropriate outlets for coping & dealing with stress? ☐ Yes ☐ No ☐ Sometimes
Describe your current stress-reduction methods (such as mediation, yoga, breathing).
Most of your stress is due to what?

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Personal Medical History

Please check all that apply to you:

Endocrine
- ☐ Thyroid
- ☐ Diabetes
- ☐ Adrenals
- ☐ Pituitary
- ☐ Other ________________

Mental Concerns
- ☐ Depression
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ ADHD
- ☐ Bipolar
- ☐ Substance Abuse
- ☐ Alcoholism
- ☐ Other ________________

Cardiac Concerns
- ☐ Subsets of Heart Attack
- ☐ Angina
- ☐ Arrhythmia
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ High Cholesterol
- ☐ Other ________________

Respiratory
- ☐ Asthma
- ☐ Emphysema
- ☐ Pulmonary Emboli
- ☐ Blood Clots
- ☐ Other ________________

Genitourinary
- ☐ Kidney Stones
- ☐ Impotence
- ☐ Infertility
- ☐ Menopause
- ☐ Fibroids
- ☐ Ovarian Cysts
- ☐ Polycystic Ovarian Syndrome
- ☐ Endometriosis
- ☐ Other ________________

Cancer

Where ____________________________________

What Kind ________________________________

When ____________________________________

Musculoskeletal
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Back or Spine Problems
- ☐ Carpal Tunnel Syndrome
- ☐ Other ________________

Gastrointestinal
- ☐ Ulcers
- ☐ Malabsortion
- ☐ Diverticulosis
- ☐ Hepatitis/Liver Disease
- ☐ Lactose Intolerance
- ☐ Other ________________

Neurology
- ☐ Seizures
- ☐ Headaches/Migraines
- ☐ Stroke
- ☐ Other ________________

General
- ☐ Glaucoma
- ☐ Epstein Barr
- ☐ Chronic Fatigue Syndrome
- ☐ Other ________________

Do you smoke? ☐ Yes ☐ No	If yes, what type?	If yes, how much (how often, how many)?	Do you want to quit? ☐ Yes ☐ No ☐ Unsure

Do you drink alcohol? ☐ Yes ☐ No	If yes, how many drinks do you have a week?	What do you drink?

Do you drink caffeine (coffee, tea, soda drinks)? ☐ Yes ☐ No	If yes, how many drinks each day?

Date of last Physical?	Date of last PSA/prostate exam?
Date of last pap smear/pelvic exam?	Date of last mammogram?

Medication Log

MEDICATION AND NUTRITIONAL SUPPLEMENT UTLIZATION
Please list the name(s), dosage, frequency and duration of all medications your are taking:

1. Name: ______________________ Dosage: __________ Frequency: __________ How Long? ________
2. Name: ______________________ Dosage: __________ Frequency: __________ How Long? ________
3. Name: ______________________ Dosage: __________ Frequency: __________ How Long? ________
4. Name: ______________________ Dosage: __________ Frequency: __________ How Long? ________
5. Name: ______________________ Dosage: __________ Frequency: __________ How Long? ________
6. Name: ______________________ Dosage: __________ Frequency: __________ How Long? ________
7. Name: ______________________ Dosage: __________ Frequency: __________ How Long? ________
8. Name: ______________________ Dosage: __________ Frequency: __________ How Long? ________

If you need additional space please use back of form.

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Weight History

Height	Current Weight	How long have you been at this weight?	Do you feel healthy at this weight? ☐ Yes ☐ No
What was your highest weight?		How long ago were you at this weight?	How long did you maintain this weight?
What do you think is your ideal weight?		How long ago were you at this ideal weight?	How long did you maintain this weight?
Was it easy to maintain your ideal weight? ☐ Yes ☐ No		Have you recently gained or lost weight? ☐ Gained ☐ Lost Amount:	If so, over what time frame did you gain or lose this weight?

Describe your weight history. Has it been steady? Does it yo-yo? Are you a lifetime dieter? Include any past weight-loss attempts.

What strategies for past weight loss have been successful for you?

What strategies for past weight loss have been unsuccessful for you?

Family Medical History

Please list family members who currently have/had in the past any of the following: use the following abbreviations: Mother (M), Father (F), Sister (S), Brother (B), Maternal (MAT), Paternal (P), Grandmother (GM), Grandfather (GF), Aunt (A), Uncle (U):

High Blood Pressure:	Glaucoma:	Ovarian Cancer:	Dementia or Alzheimer's Disease:
Heart Attack/Age:	Muscular Degeneration:	Other Cancer:	Celiac disease
Stroke/Age:	Osteoporosis:	Depression:	Thyroid disorder
Blood Clots:	Hip Fracture:	Bipolar/Manic Depression:	Other:
Bleeding Tendency:	Breast Cancer:	Alcohol Abuse:	
Diabetes:	Colorectal Cancer:	Substance Abuse:	

Is there anything about your family's health history that concerns you, or that you would like to discuss? ☐ Yes ☐ No

If yes - Please explain:

List date of all operations, hospitalization, major injuries, and illnesses (excluding pregnancy):

SURGERIES/HOSPITALIZATIONS

Year	Reason

MAJOR INJURIES OR ILLNESSES

Year	Reason

Food and Eating

Food Frequency

How often do you eat the following foods? Check the appropriate box next to each food.

Never	Once a Month	Once a Week	2 to 4 times a Week	Daily		Never	Once a Month	Once a Week	2 to 4 times a Week	Daily	
☐	☐	☐	☐	☐	Fruit & fruit juices	☐	☐	☐	☐	☐	Poultry
☐	☐	☐	☐	☐	Vegetables & vegetable juices	☐	☐	☐	☐	☐	Eggs
☐	☐	☐	☐	☐	Soy/soy foods	☐	☐	☐	☐	☐	Condiments
☐	☐	☐	☐	☐	Nuts/seeds	☐	☐	☐	☐	☐	Butter/Margarine
☐	☐	☐	☐	☐	Nut butters (i.e. peanut butter)	☐	☐	☐	☐	☐	Olive oil/canola oil
☐	☐	☐	☐	☐	Beans/legumes	☐	☐	☐	☐	☐	Other fats/oils
☐	☐	☐	☐	☐	Dairy/calcium-rich foods	☐	☐	☐	☐	☐	Fried foods
☐	☐	☐	☐	☐	Snack/junk food	☐	☐	☐	☐	☐	Desserts
☐	☐	☐	☐	☐	"White" processed foods	☐	☐	☐	☐	☐	Candy/soda
☐	☐	☐	☐	☐	Whole grains	☐	☐	☐	☐	☐	Alcohol
☐	☐	☐	☐	☐	Fish	☐	☐	☐	☐	☐	Caffeine
☐	☐	☐	☐	☐	Red Meat	☐	☐	☐	☐	☐	Water/Other beverages

How long have you been eating like this?______________________________

Do you eat like this consistently? ☐ Yes ☐ No   Have you recently made any changes to your diet? ☐ Yes ☐ No

If so, what are they? ______________________________

When did you implement these changes?______________________________

Are you conscious of what and how much you put in your mouth? ☐ Yes ☐ No ☐ Sometimes

Are you an emotional eater? ☐ Yes ☐ No ☐ Sometimes

How often do you your emotions drive you to eat?______________________________

Do you eat more on days that you're overly stressed? ☐ Yes ☐ No

How often do you feel overly stressed?______________________________

Do you eat more when you're tired? ☐ Yes ☐ No ☐ Sometimes

How often are you lacking sleep and feeling tired?______________________________

Are you often ravenous before meals? ☐ Yes ☐ No

Are you often overly full at the end of a meal? ☐ Yes ☐ No

How many meals do you eat AT home each week (include breakfast, lunch & dinner)?____________________

How many meals do you eat AWAY from home each week?______________________________

Which meals do you most often eat AWAY from home? ☐ Breakfast ☐ Lunch ☐ Dinner

Do you like to cook? ☐ Yes ☐ No   Do you feel you eat a wide variety of foods? ☐ Yes ☐ No ☐ Unsure

Do you drink enough water throughout the day? ☐ Yes ☐ No ☐ Unsure

Do you feel bored with the foods you eat? ☐ Yes ☐ No ☐ Sometimes

Do you have a history of following fad diets? ☐ Yes ☐ No

If yes, which ones have you followed? ______________________________

What are your overall nutritional goals?______________________________

How ready and willing are you to make the changes necessary for achieving your goals?

Not at all Ready or Willing			Slightly Ready & Willing				Fairly Ready & Willing			Very Ready & Willing
0	1	2	3	4	5	6	7	8	9	10

A Typical Day's Food Intake

In the appropriate column below, write down the typical foods you eat from day to day. Include everything that passes your lips, including fluid intake and solid foods. Also record portion sizes according to the Portion Size chart below.

	Weekdays	Weekends
Breakfast		
Morning Snack		
Lunch		
Afternoon Snack		
Dinner		
Evening Snack		
Midnight Snack		

Hormone Questionnaire For Women Only

Please review the symptom check list below and indicate any symptoms you are experiencing.

Symptom	None	Mild	Moderate	Severe	
Hot Flashes					Low Estrogen
Night Sweats					
Vaginal Dryness					
Incontinence					
Bleeding Changes					Estrogen Dominance
Uterine Fibroids					
Water Retention					
Tender Breasts					
Fibrocystic Breasts					
Increased Forgetfulness					
Foggy Thinking					
Tearful					
Depressed					
Mood Swings					
Stress					Adrenal
Morning Fatigue					
Difficulty Sleeping					
Decreased Stamina					
Anxious					
Irritable					
Nervous					
Fibromyalgia					
Allergies					
Headaches					
Sugar Cravings					
Dizzy Spells					
Cold Body Temperature					Thyroid
Goiter					
Hoarseness					
Hair Dry or Brittle					
Nails Breaking or Brittle					
Constipation					
Slow Pulse Rate					
Rapid Heartbeat					
Heart Palpitations					
Infertility Problems					
Acne					Metabolic Syndrome High Androgens
Increased Facial/Body Hair					
Scalp Hair Loss					
Weight Gain – Hips					
Weight Gain – Waist					
High Cholesterol					
Elevated Triglycerides					Low Androgen /Other
Decreased Libido					
Decreased Muscle Size					
Thinning Skin					
Ringing in Ears					
Rapid Aging					
Aches and Pains					
Bone Loss					

Hormone Questionnaire For Men Only

Please review the symptom check list below and indicate any symptoms you are experiencing.

Symptom	None	Mild	Moderate	Severe	
Decreased Urine Flow					Estrogen Dominance
Increased Urinary Urge					
Prostate Problems					
Weight Gain – Chest / Hips					
Weight Gain – Waist					
Decreased Libido					Metabolic Syndrome/ Low Androgens
Low Androgens					
Decreased Erections					
Ringing in Ears					
High Cholesterol					
Elevated Triglycerides					
Hot Flashes					
Night Sweats					
Decreased Mental Sharpness					
Increased Forgetfulness					
Decreased Muscle Size					
Decreased Flexibility					
Sore Muscles					
Increased Joint Pain					
Bone Loss					
Rapid Aging					
Thinning Skin					
Decreased Stamina					
Burned Out Feeling					Adrenals
Stress					
Morning Fatigue					
Evening Fatigue					
Difficulty Sleeping					
Apathy					
Depressed					
Mental Fatigue					
Anxious					
Irritable					
Nervous					
Headaches					
Sugar Cravings					
Dizzy Spells					
Cold Body Temperature					Thyroid/Other
Goiter					
Hoarseness					
Hair Dry or Brittle					
Constipation					
Slow Pulse Rate					
Rapid Heartbeat					
Heart Palpitations					
Infertility problems					
Allergies					

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Consent for the Evaluation & Treatment of Tampa Rejuvenations Medical Program

I authorize and give my Consent to Tampa Rejuvenation and its Medical Doctors, and such other physicians, associates, technicians, pharmacists, as well as any other health care personnel of Tampa Rejuvenation for the evaluation and treatment of my Medical Weight Loss and/or Hormone Therapy Program by the administration of prescribed medication while under the supervision of Tampa Rejuvenation's Medical Doctors.

I understand and am fully satisfied with the knowledge, that there are risks (both known and unknown) to any medical procedure, treatment and therapy; including the proposed treatment for Medical Weight Loss and/or Hormone Therapy and that it is not possible to guarantee or give assurance of a successful result. I freely acknowledge and accept these known and unknown general risks.

I appreciate, understand, and agree to follow the proposed treatment and therapy as prescribed by Tampa Rejuvenations Medical Doctors without any deviation, including the fact that I may be responsible for injecting, taking by mouth, applying to my skin, or other designated therapies that may be prescribed to me possibly more than once daily. Furthermore I consent to periodically have my blood drawn, saliva acquired, or urine specimens obtained for laboratory monitoring and analysis as required by Tampa Rejuvenation Medical Doctors.

I also agree to take the medical weight loss, dietary supplements, hormone preparations, and other designated therapies on the schedule that has been individually provided to me, as prescribed specifically in detail. I have completely and faithfully disclosed my complete medical history, all prescription and non-prescription medications that I am currently taking or plan to take during my treatment, as well as any other over the counter medications, recreational drugs or social substances, herbs, extracts, and other dietary supplements to you. I agree to completely follow the recommendations regarding the continuation or discontinuation of these preparations. In the future, I will receive prior authorization in advance from you, before stopping any of the prescribed therapeutic regimens or taking any additional preparations by you.

I also understand that the use of “social substances” such as tobacco, “street drugs,” and alcohol and other types of otherwise non-described “social substances” may affect my therapy in a significantly adverse manner or way.

I also understand that Tampa Rejuvenation does not bill insurance however they will for the Patients benefit, submit my given insurance to the required laboratories for testing. Tampa Rejuvenation is not responsible for insured services rendered. I hereby state my understanding of my sole responsibility with any and all unpaid balances should they arise from my insurance company.

By signing this, I release TAMPA REJUVENATION LLC. of any and all liability. I confirm that I have read this form in its entirety or it has been read to me if I have been unable to read it, and understand there are risks associated with participating in any program offered by Tampa Rejuvenation.

____________________________ Patient Name

____________________________ Date

____________________________ Tampa Rejuvenation Staff

____________________________ Tampa Rejuvenation Physician