Infinite
WELLNESS & REJUVENATION℠

1698 Hwy 160 W., Suite 200
Fort Mill, SC 29708
P: 803-547-4343
F: 803-547-3914

www.infinitewellness.org

Please complete the Medical History Evaluation form **BEFORE** you first appointment. Please remember to bring your completed form with you at your first appointment.
****If you do not bring your completed Medical History Evaluation form, we will have to reschedule you for another day****

You may also fax, email, or bring it to office ahead of time, but please bring a paper copy with you at the time of visit.

You also may want to bring:

1. Current or past prescriptions for hormones
2. Current supplements you are taking (so we can know the ingredients in them)
3. Previous lab results that might aid Infinite Wellness in your treatment

Infinite Wellness
MALE MEDICAL HISTORY EVALUATION FORM

Today's date: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____ Cell phone: _____

City: _____ State: _____ Zip Code: _____ Home phone: _____

Email address: _____ Do you regularly check email? ___Yes ___No

Height: _____ Weight: _____ Occupation _____

Primary Care Physician/Provider:
Name: _____
Address: _____
Phone: _____Fax: _____

Alternate doctor:
Name: _____
Address: _____
Phone: _____Fax: _____

		How often and how much?
Do you use tobacco?	____Yes ____ No	_____
Do you use alcohol?	____Yes ____ No	_____
Do you use caffeine?	____Yes ____ No	_____
Do you exercise regularly?	____Yes ____ No	_____

Describe typical meals.
Breakfast - _____
Lunch - _____
Dinner - _____
Snacks - _____

Allergies: Please list all that apply.
Drugs: _____
Foods: _____
Other: _____
Please describe the allergic reaction when it occurred: _____
_____

Medical Conditions/Diseases: Please check all that apply.

____ Heart disease	____ High cholesterol	____ High blood pressure	____ Cancer
____ Ulcers	____ Thyroid disorder	____ Prostate problems	____ Lung conditions
____ Blood clotting problems	____ Diabetes	____ Arthritis/joint problems	____ Depression
____ Epilepsy	____ Headaches/migraines	____ Eye disease	____ Bipolar disorder
____ Chronic Fatigue Syndrome	____ Lyme disease	____ Schizophrenia	____ Infection: please list
____ Parkinson's disease	____ Irritable Bowel Syndrome	____ Traumatic Brain Injury	____ Fibromyalgia
____ Colitis	____ Fractures	____ Eating Disorder	____ Osteoporosis
____ Kidney trouble	____ Other: please list _____		

Current Hormone Therapies:

Name Strength Date Started How often per day

_____

_____

_____

List hormones previously taken:

Name Strength (if known) Date Started Date Stopped Reason for stopping

_____

_____

_____

Current Prescriptions Medications:

Name Strength Date started How often per day

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Do you have a family history of any of the following?

_____ Cancer Family member(s) _____

_____ Hypertension Family member(s) _____

_____ Heart Disease Family member(s) _____

_____ Thyroid Disease Family member (s) _____

_____ Diabetes Family member(s) _____

_____ Osteoporosis Family member (s) _____

Have you had any of the following tests performed?

PSA _____ Date: _____ Outcome: _____

Colonoscopy _____ Date: _____ Outcome: _____

Rectal Exam _____ Date: _____ Outcome: _____

Blood pressure _____ Date: _____ Outcome: _____

Thyroid tests _____ Date: _____ Outcome: _____

Cholesterol _____ Date: _____ Outcome: _____

Triglycerides _____ Date: _____ Outcome: _____

Glucose _____ Date: _____ Outcome: _____

***If possible, please make copies of any recent lab/test results that would be helpful to us in your treatment**

Please list all **Over-The-Counter (OTC)** items you currently or occasionally use, such as antacids, pain relievers, acid blockers, laxatives, antihistamines, decongestants, cough suppressants, anti-diarrheals, sleep aids, etc. -
Do NOT include Nutritional Supplements

_____
_____
_____

Nutritional/Natural Supplements: Please identify and list the products you are using.
Vitamins (examples: multiple or single vitamins such as B complex, E, C, etc.)_____
_____
Minerals (examples: calcium, magnesium, chromium, etc.)
_____
_____
Herbs (examples: Ginseng, ginkgo biloba, etc.) _____
_____
Enzymes (examples: digestive formulas, CoEnzyme Q10, etc.)_____
_____
Nutrition/Protein supplements (examples: shark cartilage, protein powders, amino acids, fish oils, etc.) _____
_____
Other: _____
_____

What are your goals with BHRT or natural hormone replacement use?

_____
_____

Please write down any questions you have about Bio-Identical Hormone Therapy (BHRT).

_____
_____

ADAM Score
(**A**ndrogen **D**eficiency in **A**ging **M**ales) – The ADAM Score is used by physicians to determine the severity of hypogonadism in male patients.
Please circle/check the question number(s) if it pertains to you:

1. _____Do you have a decrease in libido (sex drive)?
2. _____Do you have a lack of energy?
3. _____Do you have a decrease in strength and/or endurance?
4. _____Have you lost height?
5. _____Have you noticed a decreased "enjoyment of life"?
6. _____Are you sad and/or grumpy?
7. _____Are you erections not as strong?
8. _____Have you noticed a recent deterioration in your ability to play sports?
9. _____Are you feeling asleep after dinner?
10. _____Has there been a recent deterioration in your work performance?

RESULTS: A positive questionnaire is defined as a "YES" to questions 1 or 7 OR any 3 others.

Thyroid Evaluation Form

Please indicate your severity level: **0 = None, 1 = Mild, 2 = Moderate, 3 = Severe**

SYMPTOMS

_____ Depression
_____ Dizziness
_____ Inability to lose weight
_____ Goiter (thyroid enlargement)
_____ Cold Extremities (hands & feet)
_____ Hoarseness
_____ Cold Intolerance
_____ Dry eyes
_____ Sleep disturbances
_____ Slow pulse rate
_____ Dry Hair
_____ Rapid heartbeat
_____ Heart palpitations
_____ Brittle Hair/Nails
_____ Puffy Eyelids/Face
_____ Dry Skin
_____ Acne
_____ Eczema
_____ Foggy Thinking/Forgetfulness
_____ Infertility
_____ Elevated cholesterol
_____ Fatigue
_____ Low libido (sex drive)
_____ Lack of motivation
_____ Constipation

When did these symptoms start?

_____

Is there a family history of ANY thyroid disease? Please list whom and what type (goiter, hypothyroidism, Graves' Disease, Hashimoto's Disease, etc.)

_____
_____
_____

Adrenal Questionnaire

I have not felt well since

_____when_____
(Date) (Describe event, if any)

Predisposing Factors: Check you severity level: 0 = None, 1 = Mild, 2 = Moderate, 3 = Severe

_____ I have experienced long periods of stress that have affected my well-being.
_____ I have had one or more severely stressful events that have affected my well-being
_____ I have driven myself to exhaustion
_____ I overwork with little play or relaxation for extended periods
_____ I have taken long term or intense steroid therapy
_____ I tend to gain weight, especially around the middle (spare tire)
_____ I have a history of alcoholism &/ or drug abuse
_____ I have environmental sensitivities
_____ I have diabetes (type II, adult onset, NIDDM)
_____ I suffer from post-traumatic distress syndrome
_____ I suffer from anorexia
_____ I have one or more other chronic illnesses or diseases

Energy Patterns

_____ I often have to force myself in order to keep going. Everything seems like a chore.
_____ I rely on caffeine and/or sugar to get through the day.
_____ I am easily fatigued
_____ I have difficulty getting up in the morning (don't really wake up until about 10 am)
_____ I suddenly run out of energy
_____ I usually feel much better and fully awake after the noon meal
_____ I often have an afternoon low between 3:00 – 5:00 PM
_____ I get low energy, moody, or foggy if I do not eat regularly
_____ I usually feel my best after 6:00 PM
_____ I am often tired at 9:00 – 10:00 PM, but resist going to bed
_____ I like to sleep late in the morning
_____ My best, most refreshing sleep often comes between 7:00 – 9:00 AM
_____ I often do my best work late at night (early in the morning)
_____ If I don't go to bed by 11:00 PM, I get a second burst of energy which often last until 1:00 – 2:00 AM

Hormone Symptom Survey

Instructions: Please enter the appropriate response number to each question in the columns below.

0 = None/Absent 1 = Mild or Rare 2 = Moderate 3 = Severe

Add an * (asterisk) if symptom is intermittent or "comes & goes".

_____ Burned out feeling
_____ Hot flashes/Night Sweats
_____ Decreased stamina
_____ Apathy
_____ Difficulty sleeping
_____ Decreased libido (sex drive)
_____ Decreased erections/erectile dysfunction
_____ Weight gain - waist
_____ Weight gain – breast/hips
_____ Mental fatigue/decreased mental sharpness
_____ Prostate problems
_____ Increased urinary urge
_____ Decreased urinary flow
_____ Decreased muscle mass
_____ Infertility problems
_____ Insomnia
_____ Oily skin
_____ Irritable

_____ Stress
_____ Aches and pains
_____ Nervousness/Anxiety
_____ Fibromyalgia
_____ Allergies
_____ Chemical sensitivities
_____ Headaches
_____ Sugar cravings
_____ ADD/ADHD
_____ Compulsions/Addictions
_____ Panic attacks
_____ Overwhelmed
_____ Slow recovery from illness
_____ Morning fatigue
_____ Evening fatigue
_____ High cholesterol/triglycerides

Other: _____

What are your top 3 biggest concerns/symptoms?

1. _____
2. _____
3. _____