medAge
live happier, be healthier, look better

Confidential Medical History - Male

Date: ____________

Name: ______________________ Date of Birth: ____________ Age: ________

Street Address: ____

____

City: ______________________ State: ________ ZIP: ____________

Phone: ______________________ Email: ______________________

Height ________ Weight ________

			If Yes, how often
Do you use tobacco?	____ Yes	____ No	______________________
Do you use alcohol?	____ Yes	____ No	______________________
Do you use caffeine?	____ Yes	____ No	______________________

Please list ALL the doctors that you currently see

Doctors Name	Specialty	Address	Phone

Have you ever seen a medical doctor in any of the following specialties?

(please check any and all that apply)

_____ General Practitioner
_____ Urologist
_____ Orthopedic Surgeon
_____ Cardiologist

_____ Oncologist
_____ Pain Specialist
_____ Other
____

Allergies: Please check any and all that apply:

_____ Penicillin
_____ Codeine
_____ Sulfa drugs

_____ Morphine
_____ Aspirin
_____ Food allergies

_____ Dye allergies
_____ Nitrate allergies
_____ Other

_____ Pet allergies
_____ Seasonal (pollen)
_____ No known allergies

Please describe the allergic reaction to the above allergen:

____

Please check all of the over-the-counter (OTC) products that you occasionally or regularly use.

Occasional Use	Regular Use		Occasional Use	Regular Use	
		Pain Reliever	____	____	Combination product, cough + cold reliever (ex: Triaminic®)
____	____	Aspirin	____	____	Sleep aids (ex. Excedrin PM®, Unisom®, Sominex®)
____	____	Acetaminophen (ex. Tylenol®)	____	____	Antidiarrheals (ex. Imodium®, Pepto Bismal®, aopectate®)
____	____	Ibuprofen (ex. Motrin IB®)	____	____	Laxatives/stool softeners (ex. Doxidan®, Correctol®)
____	____	Naproxen (ex. Aleve®)	____	____	Diet aids/weight loss products (ex. Desatrim®)
____	____	Ketoprofen (ex. Orudis KT®)	____	____	Antacids (ex. Maalox®, Mylanta®)
____	____	Cough suppressant (ex. Robitussin DM®)	____	____	Acid blockers (ex. Tagamet HB®, Pepcid AC®, Zantac 75®)
____	____	Antihistamine (ex. Chlor-Trimeton®)	____	____	Other (please list)
____	____	Decongestant (ex. Sudafed®)	____	____	____
			____	____	____

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

____ Vitamins (ex. multiple or single vitamins such as B complex, E, C, beta carotene)
____ Minerals (ex. calcium, magnesium, chromium, colloidal minerals, various single minerals)
____ Herbs (ex. ginseng, ginkgo biloba, echinacea, other herbal medicinal teas, tinctures, remedies, etc.)
____ Enzymes (ex. Digestive formulas, papaya, bromelain, CoEnzyme Q10, etc.)
____ Nutrition/protein supplements (ex. shark cartilage, protein powders, amino acids, fish oils, etc.)
____ Others (ex. glucosamine, etc. please list) ____________________

Medical Conditions/Disease – Please check any and all that apply to you

____ Heart disease (ex. congestive heart failure)
____ High cholesterol or lipids (ex. hyperlipidemia
____ High blood pressure (ex. hypertension)
____ Cancer
____ Ulcers (stomach, esophagus)
____ Thyroid disease
____ Hormonal related issues
____ Blood clotting problems

____ Lung condition (ex. asthma, emphysema, COPD)
____ Diabetes
____ Arthritis or joint problems
____ Depression
____ Epilepsy
____ Headaches/migraines
____ Eye disease (glaucoma, etc)
____ Other: Please list

____

____

Current Prescription Medications:

Medication	Strength	Date Started	How often per day

List any hormones that you have previously taken	Date Started	Date Stopped	Reason

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

		Family member(s)
Heart Disease		
Osteoporosis		
Diabetes		
HTN		
Stroke		
Depression		
Anxiety		
Dementia		

Have you had any of the following tests performed?

Please check those that apply and note the date of last test.

Test		No		Yes	Date:
Rectal/prostate exam/testicular exam		No		Yes	Date:
PSA test (value if known)		No		Yes	Date:
General dental cleaning		No		Yes	Date:
Colonoscopy		No		Yes	Date:
Eye exam by Optometrist or Opthalmologist		No		Yes	Date:
Full skin exam by Dermotologist		No		Yes	Date:
EKG		No		Yes	Date:
Cardiac Stress Test		No		Yes	Date:
Chest X-ray		No		Yes	Date:

Have you experienced any of the following symptoms recently?

Please check the numbered box that best describes your experiences.

1 - Extremely Mild / 10 - Extremely Severe

	1	2	3	4	5	6	7	8	9	10
Sleep Disruptions										
Fatigue										
Irritability										
Nervousness										
Dry Skin										
Mood Swings										
Arthritis										
Loss of Recent Memory										
Difficulty Concenrating										
Weight Gain										
Decreased Sex Drive										
Decreased Sexual Enjoyment										
Erectile Dysfunction										
Depression										
Headaches										
Bladder Symptoms										
Poor Response to Exercise										
Poor Recovery after Exercise										
Poor Bowel Function										
Other: ______________________										
______________________										

Do you consider yourself to be under much stress (please explain)?

____

____

____

Please select all the methods you use to relieve tension and/or stress

_____ Read
_____ Listen to music/play music
_____ Smoke cigarettes/pipe
_____ Sleep
_____ Watch television
_____ Cry
_____ Throw things

_____ Meditate
_____ Blow up
_____ Eat
_____ Exercise or walk
_____ Don't think about it
_____ Work/housework
_____ Have an alcoholic drink

_____ Do nothing
_____ Turn to faith/pray
_____ Take a mind altering drug
_____ Go for a drive
_____ Call a friend/relative
_____ Draw/paint
_____ Enjoy a hobby

If you drink alcohol or use illicit drugs on a regular basis, please answer the following:

Have you ever felt you should cut down on your alcohol or drug use?	_____ Yes	_____ No
Have people annoyed you by criticizing your alcohol or drug use?	_____ Yes	_____ No
Have you ever felt bad or guilty about your alcohol or drug use?	_____ Yes	_____ No
Have you ever drank alcohol or used drugs first thing in the morning to calm your nerves or to help you get going to face your day?	_____ Yes	_____ No

medAge is a proactive, preventative approach to healthcare designed to preserve optimum human function and moderate the process of aging prior to the onset of degenerative aging.

The **medAge** patient evaluation includes extensive medical history, lifestyle assessment, physical examination and laboratory evaluation to establish a personalized proactive treatment plan consisting of proper nutrition, exercise, stress management and appropriate medical intervention.

I have answered the questions regarding my medical history to the best of my knowledge.

I acknowledge and agree that **medAge** will be providing functional medicine and age management services and that **medAge** will not replace my general practitioner, family medicine physician and/or other medical specialists.

By signing below, I acknowledge that I understand the above and I have been adequately informed of the nature, intended purpose and risks associated with **medAge**. I acknowledge that I have been given ample opportunity to ask questions about my health status, my options and **medAge**. I hereby authorize and consent to **medAge**.

Signature: ____