OPTIMAL
HEALTH & SKIN
Face • Body • Wellness

Welcome! Please complete this new client paperwork and return to us at least 48 hours prior to your appointment. This will allow our medical team to review your case in advance of your arrival. You may email this completed document to support@optimalhealthandskin.com or use our secure fax at 1-877-788-3131. Thank you for your help and understanding. Here's to getting optimal!

GENERAL INFORMATION

Full Name:

Preferred Name and Title:

Date of Birth: Age: Gender: ____ Male ____ Female

Drug and Food Allergies:

Street Address:

City: State: Zip:

Email: Preferred Phone:

Race/Ethnicity: ___ White ___ Black or African American ___ Asian ___ Hispanic ___ Other

Emergency Contact Name: Relationship:

Emergency Contact Phone: Does Contact Live with You? ___ Yes ___ No

Primary Care Physician Name: Phone:

How did you hear about us?

INSURANCE INFORMATION

Primary Insurance Company:

ID Number: Group Number:

Insurance Street Address:

City: State: Zip:

Customer Service Phone Number:

Insured Party Name: Date of Birth:

PHARMACY INFORMATION

Pharmacy Name:

Street Address:

City: State: Zip:

Phone Number: Fax Number:

Compounding Pharmacy Name:

Phone Number: Fax Number:

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PERSONAL HEALTH & WELLNESS HISTORY

What do you hope to achieve at Optimal Health & Skin?

How can we best help you achieve your goals?

What are your top there health concerns?
1.
2.
3.

When was the last time you felt well?

Did something trigger a change in your health?

Does anything make you feel worse?

Does anything make you feel better?

FAMILY MEDICAL HISTORY

Relation	Age	Still Living?	If No, Cause Of Death	Medical Conditions
Father				
Mother				

PERSONAL CHILDHOOD HISTORY

How were you delivered? ❑ Vaginally ❑ C-Section

Did you breastfeed? ❑ Yes ❑ No

Did you experience any childhood illness? ❑ Yes ❑ No

If yes to the question above, please explain:

Additional Information:

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REVIEW OF SYMPTOMS
Please check the appropriate boxes and list date of onset.

GASTROINTESTINAL

- ❑ Constipation _____
- ❑ Diarrhea _____
- ❑ Irritable Bowel Syndrome _____
- ❑ Inflammatory Bowel Disease _____
- ❑ Celiac Disease _____
- ❑ Bloating, Gas or Belching _____
- ❑ Other _____
- ❑ Ulcerative Colitis _____
- ❑ GERD/Reflux _____
- ❑ Crohn's _____
- ❑ Stomach Pain _____
- ❑ Stomach Distention _____
- ❑ Rectal Itching _____
- ❑ Indigestion _____

CARDIOVASCULAR

- ❑ High Blood Pressure _____
- ❑ Low Blood Pressure _____
- ❑ Irregular Heart Rate/Beat _____
- ❑ Bleeding or Clotting Issues _____
- ❑ Other _____
- ❑ Heart Attack _____
- ❑ High Cholesterol _____
- ❑ Chest Pain _____
- ❑ Stroke _____
- ❑ Dizziness/Fainting _____

METABOLIC, ENDOCRINE, IMMUNE

- ❑ Type 1 Diabetes _____
- ❑ Type 2 Diabetes _____
- ❑ Low Blood Sugar _____
- ❑ Hypothyroidism _____
- ❑ Hyperthyroidism _____
- ❑ Hashimoto's Thyroiditis _____
- ❑ Endocrine Issues _____
- ❑ Multiple Chemical Sensitivities _____
- ❑ Other _____
- ❑ HIV/AIDS _____
- ❑ Hepatitis _____
- ❑ Herpes Virus _____
- ❑ Lyme's Disease _____
- ❑ Weight Gain _____
- ❑ Weight Loss _____
- ❑ Fibromyalgia _____
- ❑ Adrenal Fatigue _____
- ❑ Thinning Eyebrows _____

CANCER

Type _____ Date _____

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REVIEW OF SYMPTOMS
Please check the appropriate boxes and list date of onset.

FEMALE: HORMONES, SEXUAL HEALTH, URINARY SYSTEMS

- ❑ Heavy Menstrual Cycles _____
- ❑ Irregular Menstrual Cycles _____
- ❑ Painful Menstrual Cycles _____
- ❑ Fibrocystic Breasts _____
- ❑ Swollen/Painful Breasts _____
- ❑ Fibroids _____
- ❑ Polycystic Ovarian Syndrome (PCOS) _____
- ❑ Ovarian Cysts _____
- ❑ Vaginal Dryness _____
- ❑ Hot Flashes _____
- ❑ Night Sweats _____
- ❑ PMS _____
- ❑ Hysterectomy (Full or Partial) _____
- ❑ Other _____
- ❑ Endometriosis _____
- ❑ Hirsutism _____
- ❑ Urinary Tract Infections _____
- ❑ Yeast Infections _____
- ❑ Interstitial Cystitis _____
- ❑ Loss of Libido _____
- ❑ Nocturia (Urination at Night) _____
- ❑ Gout _____
- ❑ Low Energy _____
- ❑ Loss of Bladder Control _____
- ❑ Endometrial Ablation _____
- ❑ Endometriosis _____
- ❑ Acne/Oily Skin _____
- ❑ Infertility _____

MALE: HORMONES, SEXUAL HEALTH, URINARY SYSTEMS

- ❑ Prostate Enlargement _____
- ❑ Prostate Infection _____
- ❑ Erectile Dysfunction _____
- ❑ Difficulty Obtaining Erection _____
- ❑ Difficulty Maintaining Erection. _____
- ❑ Loss of Morning Erection _____
- ❑ Loss of Ability to Orgasm _____
- ❑ Decreased Libido _____
- ❑ Difficulty Sleeping _____
- ❑ Decreased Energy _____

RESPIRATORY DISEASE

- ❑ Seasonal/Chronic Allergies _____
- ❑ Chronic Sinusitis _____
- ❑ Other _____
- ❑ Asthma _____
- ❑ Sleep Apnea _____
- ❑ Food Allergies _____

SKIN, HAIR, NAILS

- ❑ Eczema _____
- ❑ Psoriasis _____
- ❑ Dry Skin _____
- ❑ Nail Fungal Infections _____
- ❑ Acne _____
- ❑ Hair Loss _____
- ❑ Rashes _____
- ❑ Aging Skin _____

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REVIEW OF SYMPTOMS
Please check the appropriate boxes and list date of onset.

NEUROLOGIC, MOOD

- ❑ Depression _____
- ❑ Short-Term Memory Loss _____
- ❑ Anxiety _____
- ❑ Decreased Concentration _____
- ❑ Other _____
- ❑ Forgetfulness _____
- ❑ Migraines _____
- ❑ Seizures _____
- ❑ ADD/ADHD _____
- ❑ Loss of Motivation _____

MUSCULOSKELETAL, PAIN

- ❑ Osteoarthritis _____
- ❑ Back/Neck Problems _____
- ❑ Chronic Pain _____
- ❑ Pain in Arms or Legs _____
- ❑ Swollen Joints _____
- ❑ Tingling or Numbness _____
- ❑ Radiating/Shooting Pain _____
- ❑ Accident or Injury _____
- ❑ Rheumatoid _____
- ❑ Muscle Pain _____
- ❑ Joint Pain _____
- ❑ Weakness _____
- ❑ Loss of Muscle Tone _____
- ❑ Other _____

PREVENTIVE TESTS. LIST DATE OF LAST TEST IN THE SPACE PROVIDED.

- ❑ Complete Physical Exam _____
- ❑ Cardiac Stress Test _____
  - Was your Cardiac Stress Test Normal?
  - ❑ Yes
  - ❑ No
- ❑ MRI/CT _____
  - Was your MRI/CT Normal?
  - ❑ Yes
  - ❑ No
- ❑ Other, list any abnormal findings:

_____

- ❑ EKG _____
- ❑ Colonoscopy _____
- ❑ Endoscopy _____
- ❑ Prostate Exam _____
- ❑ Mammogram _____
- ❑ Eye Exam _____
- ❑ Pap Smear _____
- ❑ Hearing Exam _____
- ❑ Pelvic Exam _____
- ❑ DEXA/Bone Density _____
- ❑ Dental Exam _____

SURGERIES

Reason: _____ Date: _____

Reason: _____ Date: _____

Reason: _____ Date: _____

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REVIEW OF SYMPTOMS
Please check the appropriate boxes and list date of onset.

SURGERIES

Reason: _____ Date: _____

Reason: _____ Date: _____

Reason: _____ Date: _____

SOCIAL HISTORY

What is your passion?

Job Title: Nature of Business:

Marital Status: Partner's Name:

Who lives at home with you?

Do you have an excessive amount of stress in your life?

What is your main source of stress?

If you currently smoke: How many packs per day? _____ How many years? _____

If you have ever smoked, how many years did you smoke?

Have you had exposure to second-hand smoke?

How many hours do you sleep per night on average?

Do you have trouble sleeping? _____ Yes _____ No

Do you wake feeling rested? _____ Yes _____ No

NUTRITION HISTORY

Height: Current Weight: Desired Weight:

Do you have weight fluctuations of more than 10 pounds? _____ Yes _____ No

Do you avoid any particular foods? _____ Yes _____ No

If you answered yes above, which types of food do you avoid?

Do you feel that you digest food well? _____ Yes _____ No

Do you feel bloated after meals? _____ Yes _____ No

What are your barriers to eating well?

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NUTRITION HISTORY, CONTINUED

Do you drink caffeine? _____ Yes _____ No	If yes, how many cups/glasses per day?
Do you drink sodas or diet sodas? _____ Yes _____ No	
Do you frequently crave sugar? _____ Yes _____ No	
Do you use sweeteners? _____ Yes _____ No	How often do you eat sugary foods?
Do you drink alcohol? _____ Yes _____ No	If yes, how many drinks per week?
Do you use recreation drugs? _____ Yes _____ No	If yes, which types?

EXERCISE HISTORY

Do you exercise? _____ Yes _____ No

Where do you exercise? _____ Home _____ Gym

What is your current exercise program (activity type, number of sessions/week, duration)?

List any problems or barriers that limit your activity:

DENTAL HISTORY

Do you have mercury fillings? _____ Yes _____ No If yes, how many?

Do you had a root canal? _____ Yes _____ No If yes, how many?

Have you had dental implants? _____ Yes _____ No

Do you have tooth or jaw pain? _____ Yes _____ No

Do you have bleeding gums? _____ Yes _____ No

Do you have gingivitis? _____ Yes _____ No

Have you had dental procedures or oral surgeries? _____ Yes _____ No If yes, provide details:

MALE HISTORY

Have you ever had your PSA level checked? ____ Yes ____No

If you have had your PSA level checked, what was the date?

If you have had your PSA level checked, was it normal? ____ Yes ____No

If you have a urologist, please provide their full name and phone number:

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FEMALE HISTORY

At what age did you have your first menstrual cycle?

Do you still have a menstrual cycle? ____ Yes ____No

What was the first day of your last cycle? How many days does your cycle last?

Are your cycles regular? ____ Yes ____No Painful? ____ Yes ____No Heavy? ____ Yes ____No

Do you use contraception? ____ Yes ____No If yes, which type(s)?

Are you pregnant or breastfeeding? ____ Yes ____No

Do you plan to become pregnant? ____ Yes ____No

Have you ever been pregnant? ____ Yes ____No

# of pregnancies: C-Sections: ____ Vaginal Deliveries: ____ Miscarriages: ____ Living Children: ____

Have you had a hysterectomy? ____ Yes ____No

If yes, which type of hysterectomy? _____ Partial (uterus only) _____ Full (uterus and ovaries)

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CURRENT PRESCRIPTION MEDICATIONS
Please attach additional sheets if necessary.

Name	Dose	Frequency	Start Date (MM/YY)	Reason

CURRENT SUPPLEMENTS

Name	Dose	Frequency	Start Date (MM/YY)	Reason

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3-DAY FOOD JOURNAL

Please list everything you consume in the next 3 days, including liquids.

DAY 1
Breakfast:
Lunch:
Dinner:
Snacks:
How did you feel today?
Did you experience any physical effects?
Did you exercise today? ____ Yes ____No Did you have a bowel movement? ____ Yes ____No

DAY 2
Breakfast:
Lunch:
Dinner:
Snacks:
How did you feel today?
Did you experience any physical effects?
Did you exercise today? ____ Yes ____No Did you have a bowel movement? ____ Yes ____No

DAY 3
Breakfast:
Lunch:
Dinner:
Snacks:
How did you feel today?
Did you experience any physical effects?
Did you exercise today? ____ Yes ____No Did you have a bowel movement? ____ Yes ____No