Created by Leslie Escalante, PA-C
Phone (512) 913-7007
Fax (512) 233-5899

Balanced Health & Beauty LLC
13343 Hwy 183 North
Suite 230
Austin, TX 78750

Today's Date: _______/_____/________

Name:		
Gender: ☐ **M** ☐ **F**	**DOB:**	**Age:**
Occupation:	**Height:**	**Weight:**

Medical Conditions/Diseases/Testing:

Overall how would you rate your health?	☐ Excellent	☐ Good	☐ Fair	☐ Poor
How do you rate your energy level?	☐ High	☐ Fairly High	☐ Low	☐ Poor
How do you rate your stress level?	☐ High	☐ Tolerable	☐ Good	☐ Ideal
Do you exercise at least once a week?	☐ Yes	☐ No		
How often do you exercise every week?	☐ Once	☐ Twice	☐ Three times or more	
What type of exercise do you do?	☐ Aerobic	☐ Anaerobic /Strengthening	☐ Both	

Do you have any medical conditions? Please check all that apply to you.

- ☐ Heart disease
- ☐ High Cholesterol or lipids
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Ulcers
- ☐ Thyroid disease
- ☐ Hormonal Related Issues
- ☐ Lung condition /Asthma
- ☐ Blood Clotting Problems
- ☐ Diabetes
- ☐ Arthritis or joint problems
- ☐ Depression
- ☐ Epilepsy
- ☐ Headaches/migraines
- ☐ Immune system disorders
- ☐ Others:_____________________________________

What Surgeries have you had, and what year?

Have you had any of the following tests performed? Check those that apply and note date of the last test.

Digital Rectal Exam	☐ No	☐ Yes	Date: _____________	☐ Normal	☐ Abnormal
Colonscopy	☐ No	☐ Yes	Date: _____________	☐ Normal	☐ Abnormal
Bone density	☐ No	☐ Yes	Date: _____________	☐ Normal	☐ Abnormal

Current Prescription Medication(s):			
Medication Name	Strength	Date Started	How often per day

List Hormones Previously Taken: Date Started	Date Stopped	Reason

Over-the-counter (OTC) issues: Please check all products that you use occasionally or regularly. Check all that apply.	
□ Pain reliever	□ Sleep aids (examples: Excedrin PC®, Unisom®, Sominex®, Nytol®)
□ Aspirin	□ Antidiarrheals (examples: Imodium®, Pepto Bismol®, Kaopectate®)
□ Acetaminophen (example: Tylenol®)	□ Diet aids/ weight loss products (example: Dexatril®)
□ Ibuprofen (example: Motrin®)	□ Antacids (examples: Tagamet HB®, Pepcid C®, Zantac 75®)
□ Naproxen (example: Aleve®)	□ Others: ____
□ Ketoprofen (example: Orudis KT®)	
□ Cough suppressant (example: Robitussin DM®)	
□ Antihistamine product (example: Chlor-Trimeton®)	
□ Combination product (cough + cold reliever) (example: Triaminic DM®)	

Nutritional/Natural Supplements: Please identify and check the products you are using:
□ Vitamins (examples: multiple or single vitamins such as B complex, E, C, beta carotene)
□ Minerals (examples: calcium, magnesium, chromium, colloidal minerals, various single minerals)
□ Herbs (examples: Ginseng, Ginkgo Biloba, Echinacea, other herbal medicinal teas, tinctures, remedies, etc.)
□ Enzymes (examples: digestive formulas, papaya, bromelain, CoEnzyme Q10 etc.)
□ Nutrition/protein supplements (examples: shark cartilage, protein powers, amino acid, fish oils, etc.)
□ Others (glucosamine, etc.)

Allergies: Please check all that apply.		
□ No known allergies	□ Aspirin	□ Penicillin
□ Codeine	□ Food allergies	□ Pet allergies
□ Sulfa drug	□ Dye allergies	□ Seasonal(pollen)allergies
□ Morphine	□ Nitrate allergies	□ Others:________________________

Please describe the allergic reaction you experienced and when it occurred?

FAMILY HISTORY

PARENTS/CHILDREN

MOTHER:	**AGE:**______________	**CONDITION:**____________________ ____________________ ____________________
FATHER:	**AGE:**______________	**CONDITION:**____________________ ____________________ ____________________
SISTERS:	**AGE:**______________	**CONDITION;**____________________ ____________________ ____________________
BROTHERS:	**AGE:**______________	**CONDITION:**____________________ ____________________ ____________________
CHILD/CHILDREN: **GENDER:** ☐ M ☐ F	**AGE:**______________	**HEALTH:**____________________ ____________________ ____________________
GENDER: ☐ M ☐ F	**AGE:**______________	**HEALTH:**____________________ ____________________ ____________________
GENDER: ☐ M ☐ F	**AGE:**______________	**HEALTH:**____________________ ____________________ ____________________
GENDER: ☐ M ☐ F	**AGE:**______________	**HEALTH:**____________________ ____________________ ____________________

Do y ou have family history of any of the following?(Relation with the family member)

Skin Conditions	□ No	□ Yes	Family member(s)	________________________
Obesity	□ No	□ Yes	Family member(s)	________________________
Uterine Cancer	□ No	□ Yes	Family member(s)	________________________
Ovarian Cancer	□ No	□ Yes	Family member(s)	________________________
Fibrocystic breast	□ No	□ Yes	Family member(s)	________________________
Breast Cancer	□ No	□ Yes	Family member(s)	________________________
Heart Disease	□ No	□ Yes	Family member(s)	________________________
Osteoporosis	□ No	□ Yes	Family member(s)	________________________
Depression	□ No	□ Yes	Family member(s)	________________________
Diabetes	□ No	□ Yes	Family member(s)	________________________

Doctors' Names:	Specialty:	Address:	Phone:

SOCIAL HISTORY		
Do you use tobacco?	☐ Yes ☐ No	How often and how much?
Do you consume alcohol?	☐ Yes ☐ No	
Do you use caffeine?	☐ Yes ☐ No	

I. ENERGY LEVEL

How would you rate your energy level on a scale from 1-10, 1 means you barely function and 10 means you radiate energy?	___/10
Do you feel you should have more energy?	☐ Yes ☐ No
How long have you been feeling this way?	________ Year(s)
Do you feel a constant (background) tiredness or fatigue?	☐ Yes ☐ No
Do you wake up tired?	☐ Yes ☐ No
Do you have energy swings?	☐ Yes ☐ No
Are you run down around 4:00 p.m.?	☐ Yes ☐ No
Do you eat something sweet when you feel this way?	☐ Yes ☐ No
Do you feel better at these times after you eat something sweet?	☐ Yes ☐ No
Are you easily exhausted with physical activity?	☐ Yes ☐ No
Do you have difficulty handling stress?	☐ Yes ☐ No
Is it difficult for you to stay up late (after midnight)?	☐ Yes ☐ No
Do you get very tired in the evening or early night?	☐ Yes ☐ No
Do you feel more tired when you are at rest than when you are active?	☐ Yes ☐ No

Do you have difficulty recovering after having stayed up late night the night before (after midnight)?	☐ Yes ☐ No
Do you feel like you are living in slow motion?	☐ Yes ☐ No

II. THYROID

Have you ever been diagnosed with a thyroid disorder?	☐ Yes ☐ No
If yes, year diagnosed.	____________
Are you Hyperthyroid (high) or Hypothyroid (low)?	☐ Hyperthyroid ☐ Hypothyroid
Do you or have you ever taken thyroid medication?	☐ Yes ☐ No
If yes, how long?	____________
If yes, what brand and dose?	______, _____mg ________how often?
If not at this time, what year did you quit taking medication?	______________

III. WEIGHT CONTROL

Have you had any significant weight gain?	☐ Yes ☐ No
How many pounds?	________ lbs.
What year did it start?	_________
Do you feel you put on weight easily?	☐ Yes ☐ No
Do you have difficulty losing weight?	☐ Yes ☐ No
How long have you had this problem?	________ Year(s)
Do you put on weight around your waist?	☐ Yes ☐ No
Do you put on weight around your thighs and buttocks?	☐ Yes ☐ No
Do you have a flabby abdomen or a “spare tire”?	☐ Yes ☐ No
Are you pear-shaped?	☐ Yes ☐ No
Is your upper abdomen distended?	☐ Yes ☐ No
Is your lower abdomen distended?	☐ Yes ☐ No
Do you suffer from constipation?	☐ Yes ☐ No

IV. TEMPERATURE SENSITIVITY

Are you sensitive to cold?	☐ Yes ☐ No
Do your hands and feet feel cold?	☐ Yes ☐ No
How long have you experienced this?	________ Year(s).
Do you get chills easily?	☐ Yes ☐ No
Do the palms of your hands or feet perspire unusually?	☐ Yes ☐ No
How long have you experienced this?	_______ Year(s).
Do you have decreased perspiration?	☐ Yes ☐ No
How long have you experienced this?	________ Year(s).

V. MOOD AND MEMORY

Do you ever feel discouraged, blue or depressed?	☐ Yes ☐ No
If yes, what percentage of the time?	________ %
How long have you felt this way?	________ Year(s).
Do you or have you ever taken antidepressants?	☐ Yes ☐ No
If yes, which ones?	________
If yes, between what ages?	________
Are you ever anxious, nervous or irritable?	☐ Yes ☐ No
Do you lose self-control?	☐ Yes ☐ No
Do you have difficulty making decisions or setting goals	☐ Yes ☐ No
Are you less self-confident now?	☐ Yes ☐ No
If yes, how long have you been this way?	☐ Yes ☐ No
Do you tend to isolate yourself?	☐ Yes ☐ No
Are you intolerant of noise?	☐ Yes ☐ No
Do small things set you off?	☐ Yes ☐ No
Have you noticed a decrease in mental sharpness?	☐ Yes ☐ No

Do you have a poor short-term memory?	☐ Yes ☐ No
Do you have trouble concentrating?	☐ Yes ☐ No

VI. SLEEP

How many hours do you sleep each night, on average?	___________________
Do you feel you need a lot of sleep?	☐ Yes ☐ No
Do you have trouble falling asleep at night?	☐ Yes ☐ No
Is your mind filled with thoughts as you are trying to go to sleep?	☐ Yes ☐ No
Do you wake up during the night?	☐ Yes ☐ No
Can you go back to sleep easily during the night?	☐ Yes ☐ No
Do you have nervous, anxious or restless sleep?	☐ Yes ☐ No
Do you have a tendency to go to bed late and wake up late in the morning?	☐ Yes ☐ No
Do you have difficulty waking up in the morning?	☐ Yes ☐ No
Do you wake up too early with a heavy head in the morning?	☐ Yes ☐ No
When you get up in the morning, are you rested?	☐ Yes ☐ No
Do you take something to help you sleep?	☐ Yes ☐ No
If yes, what do you use?	___________________

VII. HAIR

Do you have fine hair or coarse hair?	_________Fine _________Coarse
How long have you had this type of hair?	_________ Year(s)
Are your eyebrows or eyelashes thinning?	☐ Yes ☐ No
Do you have hair loss or thinning of hair on your head?	☐ Yes ☐ No
Do you have dry, thick, brittle hair?	☐ Yes ☐ No
Does your hair grow slowly?	☐ Yes ☐ No
Do you have less armpit hair?	☐ Yes ☐ No

Do you have less pubic hair?	☐ Yes	☐ No
Is your hair graying?	☐ Yes	☐ No
Is your hairline receding?	☐ Yes	☐ No
Is it receding on the sides of the forehead?	☐ Yes	☐ No
Are you losing your hair on top of your head?	☐ Yes	☐ No

VIII. SKIN

Do you have fine lines or crow's feet at the side of the eyes?	☐ Yes	☐ No
Do you have lines on your forehead?	☐ Yes	☐ No
Does the skin of your face look puffy, pale or doughy?	☐ Yes	☐ No
Is the skin on the back of your hands thin?	☐ Yes	☐ No
Do you have lines on the side of your mouth?	☐ Yes	☐ No
Do you have dry skin?	☐ Yes	☐ No
If yes, since when?	_________ Year(s).	
Do you have rosacea (redness on the nose and cheeks)?	☐ Yes	☐ No
Do you have eczema, psoriasis or other rashes?	☐ Yes	☐ No
Do you have age spots?	☐ Yes	☐ No
Do you have thin, vertical wrinkles above your lips?	☐ Yes	☐ No
Do your cheeks sag?	☐ Yes	☐ No
Are your nails brittle?	☐ Yes	☐ No
Do you have acne?	☐ Yes	☐ No

IX. EYES

Do you have swelling or puffiness around your eyes or your face in the morning?	☐ Yes	☐ No
Do you have swollen eyelids in the morning?	☐ Yes	☐ No
Do you have dark circles under your eyes?	☐ Yes	☐ No
How long have you had any of these problems?	_________ Year(s).	

Does the swelling occur often?	☐ Yes	☐ No
Do your eyes feel dry?	☐ Yes	☐ No
Do you see as brightly as before?	☐ Yes	☐ No
Do you wear corrective lenses of any sort?	☐ Yes	☐ No

X. MUSCULO-SKELETAL

Do you feel your muscles are flabby or slack?	☐ Yes	☐ No
Do your joints get stiff in the morning?	☐ Yes	☐ No
Do you have arthritis?	☐ Yes	☐ No
If yes, where?	____________________	
Do you have osteoarthritis of the hips?	☐ Yes	☐ No
Do you have muscular pain?	☐ Yes	☐ No
If yes, where?	____________________	
Do you have bone loss or osteoporosis?	☐ Yes	☐ No
Do you suffer from low back pain?	☐ Yes	☐ No
Are your exercise work-outs less effective?	☐ Yes	☐ No

FOR MEN ONLY

Question	Yes	No
Do you feel less confident and more hesitant?	☐ Yes	☐ No
Does you beard grow more slowly now?	☐ Yes	☐ No
Are your breasts getting fatty?	☐ Yes	☐ No
Do you have hot flashes and sweats?	☐ Yes	☐ No
Do you lack sexual desire?	☐ Yes	☐ No
Have you lost attraction towards your partner?	☐ Yes	☐ No
Do you feel like making love less often than you used to?	☐ Yes	☐ No
Is sexual intercourse as pleasurable as it used to be?	☐ Yes	☐ No
Do you feel your sexual performance is poorer than it used to be?	☐ Yes	☐ No
Does your penis seem less sensitive?	☐ Yes	☐ No
Has your penis changed in dimension?	☐ Yes	☐ No
Are you able to obtain an erection?	☐ Yes	☐ No
Are you able to maintain an erection?	☐ Yes	☐ No
Are your erections firm enough?	☐ Yes	☐ No
Are you able to achieve orgasm?	☐ Yes	☐ No
Have you or do you use medication for erectile dysfunction, such as Viagra?	☐ Yes	☐ No

YOUR COMMENTS