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.

Mammography	□ No	□ Yes	Date: _____	□ Normal	□ Abnormal
PAP Smear	□ 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 you 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 WOMEN ONLY

I. MENSTRUAL SYMPTOMS

Do you have?

Breast tenderness?	☐ Yes	☐ No
Fluid retention?	☐ Yes	☐ No
Hot flashes?	☐ Yes	☐ No
Night sweats?	☐ Yes	☐ No
Cravings?	☐ Yes	☐ No
Menstrual Cramps?	☐ Yes	☐ No
Bloating?	☐ Yes	☐ No
Anxiety?	☐ Yes	☐ No
Insomnia?	☐ Yes	☐ No
Heart palpitations?	☐ Yes	☐ No
Mood Swings?	☐ Yes	☐ No
Weight Gain?	☐ Yes	☐ No
Headaches?	☐ Yes	☐ No
Fatigue?	☐ Yes	☐ No
Irritability?	☐ Yes	☐ No
Depression?	☐ Yes	☐ No
Forgetfulness?	☐ Yes	☐ No
Crying?	☐ Yes	☐ No
Have any of the above symptoms caused you to be unable to carryout your daily responsibilities?	☐ Yes	☐ No
Are you growing facial hair?	☐ Yes	☐ No

II. MENSTRUAL PERIODS

What was the date of your last normal menstrual cycle?	_____
At what age did your menstrual periods start?	_____ years old.
Do you still have menstrual periods?	☐ Yes ☐ No
Do your menstrual periods occur at about the same time each month?	☐ Yes ☐ No
If no, what is the shortest number of days between periods?	_____ days.
If no, what is the longest number of days between periods?	_____ days.
How long have your menstrual cycles been irregular?	_____ months to_____ years.

Were your menstrual cycles ever regular?	☐ Yes ☐ No
If yes, when?	
How many days do your periods last?	_____ days.
Are your periods heavier or lighter than in the past?	☐ Heavier ☐ Lighter ☐ Same
If so, when did they change?	_____/_____ (month/year)
Do you have bleeding that occurs between your normal periods?	☐ Yes ☐ No

III. BREASTS

Do you feel your breasts are droopy?	☐ Yes ☐ No
Are your breasts swollen, tender or painful before your menstrual periods?	☐ Yes ☐ No
Do you have fibrocystic breast disease?	☐ Yes ☐ No
If so, for how long?	_____
Have you had an abnormal discharge from your breasts?	☐ Yes ☐ No
If yes, what color?	_____
If yes, for how long?	_____/_____ (month(s)/year(s))
Have you had lumps in your breasts?	☐ Yes ☐ No
Have you ever had a breast biopsy?	☐ Yes ☐ No
If yes, how many times?	_____
If yes, when?	_____
Have you had your breast(s) aspirated?	☐ Yes ☐ No
If yes, how many times?	_____
Do you have breast implants?	☐ Yes ☐ No
If yes, when was the surgery performed?	_____
Are they saline or silicone?	☐ Saline ☐ Silicone

IV. BLADDER / OVARIES/ VAGINA/ UTERUS

Do you urinate frequently?	☐ Yes ☐ No
Do you get recurrent bladder infections?	☐Frequently ☐ Occasionally ☐ Rare
Do you lose urine when you cough or sneeze?	☐ Yes ☐ No
Have you had ovarian cysts?	☐ Yes ☐ No
If yes, how many times?	
Have you ever had endometriosis?	☐ Yes ☐ No
If yes, for how long?	_____/_____ (month(s)/year(s))
Have you ever had uterine fibroids?	☐ Yes ☐ No
If yes, for how long?	_____/_____ (month(s)/year(s))
Do you have vaginal dryness?	☐ Yes ☐ No
If yes, for how long?	/ (month(s)/year(s))
Have you had a hysterectomy?	☐ Yes ☐ No Date of surgery:_____
Were your ovaries removed?	☐ Yes ☐ No

V. BIRTH CONTROL

Have you had a tubal ligation?	☐ Yes ☐ No
If yes, when?	_____/_____(month/year)
Have you ever used birth control pills?	☐ Yes ☐ No
If yes, for how long?	_____/_____(month(s)/year(s))
Have you discontinued taking birth control pills?	☐ Yes ☐ No
When did you discontinue taking birth control pills?	_____/_____(month/year)
Are you currently using an IUD?	☐ Yes ☐ No
Have you ever taken Depo-Provera?	☐ Yes ☐ No
Are you currently taking estrogen?	☐ Yes ☐ No
Are you currently taking progesterone?	☐ Yes ☐ No
Are you currently taking any other hormones?	☐ Yes ☐ No
If yes, which one(s)?	_____

VI. SEX

Do you have a decrease in sexual desire?	☐ Yes ☐ No
If yes, for how long?	_____/_____(month(s)/year(s))
Do you find it more difficult to achieve orgasm?	☐ Yes ☐ No
Are you able to achieve orgasm?	☐ 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
Have you ever had pain during intercourse?	☐ Yes ☐ No
Have you ever had pain after intercourse?	☐ Yes ☐ No
Is this pain due to vaginal dryness?	☐ Yes ☐ No

VII. PREGNANCY

How many pregnancies have you had?	_____
How many live births have you had?	_____
How many miscarriages have you had?	_____
How many children do you have?	_____
What is the date of your last child's birth?	_____
How old were you at the time of your last delivery?	_____years old.
Did you have difficulty becoming pregnant?	☐ Yes ☐ No
Did you ever receive infertility treatment?	☐ Yes ☐ No
If yes, what kind?	_____