AXIS REJUVENATION

NAME: _____ DATE: _____

ADDRESS: _____CITY: _____STATE: _____

ZIP: _____ CELL #: _____ HOME #: _____

SOC SECURITY #: _____ DATE OF BIRTH: _____

DRIVERS LICENSE NUMBER: _____ STATE: _____

EMAIL ADDRESS: _____

MARITAL STATUS: ( ) SINGLE ( ) MARRIED ( ) DIVORCED ( ) WIDOWED ( ) SEPERATED ( ) UNDISCLOSED

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY NAME: _____

POLICY HOLDER'S NAME: _____

POLICY HOLDER'S SOCIAL SECURITY NUMBER: _____

ID NUMBER (if different from social security number: _____

GROUP NUMBER:_____

TYPE OF INSURANCE PLAN: ( ) HMO ( ) PPO ( ) MEDICAID ( ) MEDICARE ( ) OTHER

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY NAME: _____

POLICY HOLDER'S NAME: _____

POLICY HOLDER'S SOCIAL SECURITY NUMBER: _____

ID NUMBER (if different from social security number: _____

GROUP NUMBER:_____

TYPE OF INSURANCE PLAN: ( ) HMO ( ) PPO ( ) MEDICAID ( ) MEDICARE ( ) OTHER

AXIS REJUVENATION

PATIENTS EMPLOYER: _____ WORK #: _____

BUSINESS ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMPLOYER: _____ WORK #: _____

EMERGENCY CONTACT: _____ PHONE: _____

RELATIONSHIP TO PATIENT: _____ DATE OF BIRTH: _____

ADDRESS: _____

CONTACT #: _____ ( ) CELL ( ) HOME

PATIENT SIGNATURE: _____ DATE: _____

HOW DID YOU HEAR ABOUT US? (Radio Station, TV Commercial, Facebook, Twitter, Friend,Other)_____

WHOM MAY WE THANK FOR REFERRING YOU? _____

AXIS REJUVENATION

Patient Name: _____ DOB: _____ Date: _____

Occupation: _____

Primary Care Doctor (PCP): _____ Phone number: _____

Pharmacy Number: _____ Date of last physical exam: _____

**Personal Health History**

**Please circle all that apply:**

| | | | |
|---|---|---|---|
| General | Diabetes | High Cholesterol | Unwanted Weight Loss |
| Cancer | Personal History of Cancer | Family History of Cancer_____ | Autoimmune Disorder_____ |
| Cardiovascular | Heart Failure | Heart Attack | Heart Murmur |
| | Vascular Disease | Blood Cots | Edema |
| | Hypertension | Irregular Heartbeat | Congestive Heart Failure |
| Respiratroy | Sleep Apnea | Shortness of Breath | Asthma/ COPD |
| | Bronchitis | Pneumonia | Allergies |
| Gastrointestinal | Lactose Intolerance | Gall Bladder | Gall Stones |
| | Chronic Diarrhea | Chronic Constipation | |
| Genitourinary | Prostate Cancer | Prostate Cancer In Family | Overactive Bladder |
| | Painful Urination | Decreased Urinary Force | ON/OFF Urine Flow |
| | Enlarged Prostate | Blood in Urine | Kidney/Bladder History |
| Infection | Kidney/Bladder | Liver | Any other |
| Psychiatric | History of Depression | Personality Disorder | Any other |

AXIS REJUVENATION

List your prescribed drugs and any over-the-counter drugs, such as vitamins and inhalers. Please make sure, to include any anti-anxiety or anti-depressant medications.

Drug Name _____ Dosage _____ Frequency _____

Taken for _____

Drug Name _____ Dosage _____ Frequency _____

Taken for _____

Drug Name _____ Dosage _____ Frequency _____

Taken for _____

Allergies: _____ No Known Allergies or List Allergies and Reaction

_____

_____

Surgeries:

Year _____ Surgery/Reason _____

Year _____ Surgery/Reason _____

HEALTH HABITS AND PERSONAL SAFETY

Exercise: _____ Sedentary (No exercise) _____ Mild exercise _____ Occasional vigorous exercise _____

Regular vigorous exercise

Describe type of exercise and frequency (resistance training, cardiovascular, number of times per week)

_____

_____

_____

Pregnancies: _____

Number of children: _____

Hysterectomy: _____ If yes when: _____

Last menstrual cycle: _____

Rate your quality of sleep: 1-Worst 10-Best

1 2 3 4 5 6 7 8 9 10

Lifestyle Questionnaire

Alcohol: ____Yes Number of drinks per week: _____ ____No

Tobacco: ____Yes _____ Cigarettes ____ Cigars ____ Chewing How many/much: _____ ____ No

Are you interested in quitting tobacco? _____

Illicit drug use: ____Yes Explain _____ ____ No

SYMPTOMS OF LOW TESTOSTERONE LEVELS

Anxiety ___ Yes ___No

Arthritis ____ Yes ____No

Bladder symptoms ____Yes ____No

Breast tenderness ____Yes ____No

Cramps ____Yes ____No

Depression ____ Yes ____No

Difficulty climaxing ____ Yes ____No

Diminished sex drive ____Yes ____No

Dry skin or hair ____Yes ____No

Fatigue ____Yes ____No

Fluid Retention ____Yes ____No

Hair Loss ____Yes ____No

Headaches ____Yes _____No

Heavy or irregular periods ____Yes ____No

Hot flashes ____Yes ____No

Insomnia or trouble sleeping ____Yes ____No

Irritability ____Yes ____No

Memory Loss ____Yes ____No

Mood Swings _____Yes ____No

Night Sweats ____Yes ____No

Vaginal dryness ____Yes ____No

Weight gain ____Yes ____No

I have had hormones checked previously ____Yes ____No

If yes when: _____ Type: _____ Usage: _____

I Hereby also declare that I will not be attending or starting any military basic/advanced individual training (AIT) school while I am a patient of Axis Rejuvenation, LLC.

Patient Name (Print) _____DOB: _____

Signature: _____Date: _____