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

PATIENTS EMPLOYER: _____ WORK #: _____

BUSINESS ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMPLOYER: _____ WORK #: _____

EMERGENCY CONTACT: _____ PHONE: _____

WHOM MAY WE THANK FOR REFERRING YOU: _____

RELATIONSHIP TO PATIENT: _____ DATE OF BIRTH: _____

DRIVER'S LICENSE #: _____ STATE: _____

ADDRESS: _____

CONTACT #: _____ ( ) CELL ( ) HOME

PATIENT SIGNATURE: _____ DATE: _____

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 Clots	Edema
	Hypertension	Irregular Heartbeat	Congestive Heart Failure
Respiratory	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 antidepressant 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)

_____

_____

_____

Have you used Testosterone (prescribed or otherwise) or any other anabolic steroids in the past? Please be completely truthful with your response - it is critical in order to diagnose and prescribe correctly.

_____

_____

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

Illicit drug use: ____Yes Explain _____ ____No

Vitals

Blood Pressure _____ Pulse _____ Respiratory Rate _____

Weight _____ Height_____

SYMPTOMS OF LOW TESTOSTERONE LEVELS

Decreased concentration ____ Yes ____No

Difficulty learning new things ____ Yes ____No

Memory loss ____ Yes ____No

Moodiness ____ Yes ____ No

Depression ____ Yes ____No

Increasing fatigue ____ Yes ____No

Decreasing energy ____ Yes ____No

Daytime sleepiness ____ Yes ____ No

Poor sleep habits ____ Yes ____No

Erectile dysfunction ____ Yes ____ No

I have had testosterone checked previously _____ Yes ____ No

I have used testosterone previously ____ Yes ____ No

If yes, date(s): _____ 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: _____