



NAME: _____ DATE: _____

ADDRESS: _____ CITY: _____ STATE: _____

ZIP: _____ CELL #: _____ HOME #: _____

SOC SECURITY #: _____ DATE OF BIRTH: _____

DRIVER'S LICENSE NUMBER: _____ STATE: _____

EMAIL ADDRESS: _____

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

PATIENT'S 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: _____

ADDRESS: _____

CITY: _____ STATE: _____

CONTACT #: _____ () CELL () HOME

PATIENT SIGNATURE: _____ DATE: _____

AXIS

REJUVENATION

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 _____

Pregnancies: _____

Number of children: _____

Hysterectomy: _____ Yes (and date) _____ No

Last menstrual period: _____

AXIS

REJUVENATION

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)

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 HORMONE 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

AXIS

REJUVENATION

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

I have used hormones 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: _____