Please take time to read this carefully and answer all the questions as completely as possible.
Please bring this completed form to your initial appointment.

Patient Information & Medical History

Name: ____Today's Date: ____________
(Last) (First) (Middle)

Date of Birth: ______________ Age: ________ Occupation: ____

Home Address: ____

City: ____ State: __________ Zip: _______________

Home Phone: _____________________ Cell Phone: _____________________ Work: ____________________

Social Security Number: ___________________ E-Mail Address: ________________________________

May we contact you via E-Mail? ( ) YES ( ) NO

In Case of Emergency Contact: ________________________________ Relationship: _____________________

Home Phone: _____________________ Cell Phone: _____________________ Work: ____________________

Primary Care Physician's Name: ___________________________________ Phone: _____________________

Address: ____
Address City State Zip

May we contact your Physician regarding your treatment? ( ) YES ( ) NO

Medical History

Any known drug allergies: ____

Medications Currently Taking: ____

____

Current Physician Prescribed Treatments: ____

Past Physician Prescribed Treatments: ____

Nutritional/Vitamin Supplements: ____

Surgeries, list all and when: ____

Other Information: ____

FOUNTAIN OF YOU MD
HORMONE & ANTI-AGING INNOVATION

Symptoms ***(please circle yes or no)***

Current Infections	Y/N	Keloids	Y/N
Burns, Boils, Blisters	Y/N	Diabetes	Y/N
HIV positive	Y/N	Recent surgery	Y/N
Use of Accutane in last 6 months	Y/N	Pregnant OR breastfeeding	Y/N
Herpes	Y/N	Seizures	Y/N
Open cuts and/or lesions	Y/N	Recent cosmetic procedure	Y/N
Melasma	Y/N	Recent waxing	Y/N
Vitiligo	Y/N	Auto Immune Disease	Y/N
Decline in general well-being	Y/N	Joint Pain / Muscle Soreness	Y/N
Excessive Sweating	Y/N	Sleep Issues	Y/N
Irritability	Y/N	Anxiety / Nervousness	Y/N
Depression	Y/N	Focus/concentration/mental clarity decline	Y/N
Exhaustion / lack of stamina	Y/N	Decreased muscle strength / mass	Y/N
Weight Gain / loss	Y/N	Rapid hair loss	Y/N
Low libido	Y/N	Migraine headaches	Y/N
High blood pressure	Y/N	High cholesterol	Y/N
Heart stroke	Y/N	Blood clot / pulmonary emboli	Y/N
Hemochromatosis	Y/N	Polycythemia	Y/N
History of Cancer	Y/N	Sleep Apnea	Y/N
Testicular or prostate cancer	Y/N	Elevated PSA	Y/N
Prostate enlargement	Y/N	Chronic liver disease	Y/N
Thyroid disease	Y/N	Arthritis	Y/N
Sickle cell	Y/N	Priapism	Y/N
Peyronie's disease	Y/N	Trouble passing urine	Y/N

_________________________ _________________________ _____________

Print Name **Signature** **Today's Date**