

Background Information

Where were you born?

Where did you spend most of your childhood?

Did you have any health issues during your childhood through high school that you consider to be unusual or significant? yes no

If yes, please elaborate here:

What health conditions or issues run in your extended family (parents, grandparents, children, grandchildren, aunts, uncles or cousins)?

Do you have any allergies or bad reactions to prescription or over-the-counter medications?

If yes, please list them along with the symptoms of the allergy or bad reaction.

What chronic medical problems do you have that you didn't mention on the previous page?

Have you had any surgeries? If yes, please list the year and the type of surgery

Current Medications and Therapies

Please list any prescription and over-the-counter medications you take, along with the dose and frequency of use.

Please list any health supplements such as vitamins, minerals, herbs, amino acids, or probiotics--along with the dose (if you know it) and frequency of use.

Please list any other doctors and other healers that you've seen in the last year along with their specialty (e.g. dermatology or ophthalmology) or training (e.g chiropractic, acupuncture, massage) and what issues you've been seeing them for.

Preventive Medical Services

Have you had any blood tests done in the past 3 months? yes no

If yes, were the tests done at: LabCorp Quest Scripps Other I don't know

If you're over 50, have you completed an Advance Directive (sometimes called a Living Will)?

Advance Directive? yes no

If you've had any of the following **vaccines**, please check the box and if you know the year, write that in the space on the right:

Flu yes no If yes, what year or how long ago:

Tetanus (Td or Tdap) yes no If yes, what year or how long ago:

Pneumovax (original) yes no If yes, what year or how long ago:

Pevnar-13 yes no If yes, what year or how long ago:

Shingles yes no If yes, what year or how long ago:

If you're over 50 or have a family history of colon cancer, have you had a colonoscopy? If yes, please write the year as best you recall:

Colonoscopy? yes no If yes, what year or how long ago:

Have you had any gene tests for colon cancer (Cologuard) or any other general gene tests such as 23andme or ancestry.com? yes no

Just for women

If you have had a mammogram, when was your most recent one as best you can recall?

Mammogram? yes no If yes, what year or how long ago:

If you have had a breast exam by a health professional, when was your most recent one as best you can recall? Breast exam? yes no If yes, what year or how long ago:

If you have had a PAP smear, when was the most recent one as best you can recall?

PAP? yes no If yes, what year or how long ago:

If you have had a bone density scan, when was the most recent one as best you can recall?

Bone density scan? yes no If yes, what year or how long ago:

Just for men

If you have had a prostate exam, when was your most recent one as best as you can recall?

Prostate exam? yes no If yes, what year or how long ago:

If you have had a PSA (prostate specific antigen) blood test, when was it as best as you can recall?

PSA? yes no If yes, what year or how long ago:

Lifestyle

Do you follow any special diet, such as low-fat, low carbo, Paleo, pescaterian, vegetarian, vegan, etc?

Special diet? yes no

If yes, please explain here:

What's your typical breakfast?

What's your typical lunch?

What's your typical dinner?

Have you had a bad reaction to any foods such as bloating, flushing, congestion? yes no

If yes, please explain:

In the last few years, have you made any changes in your diet because of your health? yes no

If yes, please explain:

How many alcohol-containing drinks do you have in a typical WEEK? _____

Do you use any tobacco-containing products? yes no

What kind of exercise do you get and how many hours per week do you spend on it?

How many hours of sleep do you usually get? _____

How do you release stress? _____

Review of Systems

Please check the box next to any other concerns that you'd like to discuss with Dr. Bressler.

<input type="checkbox"/> Anti-aging/Longevity	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Sadness
<input type="checkbox"/> Low energy	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Sleep issues	<input type="checkbox"/> Changes in Vision	<input type="checkbox"/> Stress
<input type="checkbox"/> Skin rashes	<input type="checkbox"/> Red eyes	<input type="checkbox"/> Distressing Thoughts
<input type="checkbox"/> Hair loss	<input type="checkbox"/> Dental Issues	<input type="checkbox"/> Relationship Issues
<input type="checkbox"/> Dry Skin	<input type="checkbox"/> Mouth Sores	<input type="checkbox"/> Grief
<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Voice Changes	<input type="checkbox"/> Anger
<input type="checkbox"/> Swollen Lymph Nodes	<input type="checkbox"/> Urination problems	<input type="checkbox"/> Forgetfulness
<input type="checkbox"/> Frequent Infections	<input type="checkbox"/> Low sex drive	<input type="checkbox"/> Falls
<input type="checkbox"/> Chronic cough	<input type="checkbox"/> Men: erection issues	<input type="checkbox"/> Poor Coordination
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Women: pain w/sex	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Runny or Stuffy Nose	<input type="checkbox"/> Women: other GYN issues	<input type="checkbox"/> Light-headedness
<input type="checkbox"/> Bloody nose	<input type="checkbox"/> Women: menopause issues	<input type="checkbox"/> Headaches
<input type="checkbox"/> Swallowing trouble	<input type="checkbox"/> Thyroid issues	<input type="checkbox"/> Chronic pain
<input type="checkbox"/> Weight change	<input type="checkbox"/> Blood sugar issues	<input type="checkbox"/> Stiff joints
<input type="checkbox"/> Heartburn	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Spiritual Crisis
<input type="checkbox"/> Constipation	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Work Issues
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Cold extremities	<input type="checkbox"/> STD exposure
<input type="checkbox"/> Bloating	<input type="checkbox"/> Foot or Calf pains	<input type="checkbox"/> Financial issues
<input type="checkbox"/> Abdominal pains	<input type="checkbox"/> Swelling in the feet	<input type="checkbox"/> Issues of meaning & purpose
<input type="checkbox"/> Excess Gas	<input type="checkbox"/> Back pain	<input type="checkbox"/> Trouble focusing
<input type="checkbox"/> Indigestion	<input type="checkbox"/> Muscle spasms	<input type="checkbox"/> Tremor/Shaking
<input type="checkbox"/> Illness in family member	<input type="checkbox"/> Death in family member	<input type="checkbox"/> Other