FMEDHX

CONFIDENTIAL MEDICAL HISTORY FORM

WE REALIZE THIS MEDICAL HISTORY FORM IS SOMEWHAT LONG. HOWEVER, IT IS ABSOLUTELY NECESSARY FOR US TO EVALUATE YOUR GENERAL HEALTH AND SAFELY AND LEGITIMATELY PRESCRIBE THE MEDICATIONS YOU WANT AND NEED. MAKE SURE TO TAKE A FEW MINUTES TO CAREFULLY AND COMPLETELY ANSWER EVERY QUESTION. FAILING TO DO SO WILL PREVENT US FROM HELPING YOU, AS DOING SO COULD POSSIBLY JEOPARDIZE YOUR HEALTH. DO THE BEST YOU CAN—WE WILL FOLLOW-UP WITH ANY QUESTIONS WE MAY HAVE. REMEMBER, THIS INFORMATION IS COMPLETELY CONFIDENTIAL.

Please initial here that you have read the above statement: _____

I am a NEW/ESTABLISHED patient (circle one).
Password (established patients only):

1. First name:
2. Middle name:
3. Last name:
4. Address:
5. City:
6. State:
7. Zip code:
8. Shipping address (if different than address above):
9. City:
10. State:
11. Zip code:

CONTACT INFORMATION

12. Email:
13. Repeat Email Address [to confirm]:
14. Daytime phone:
15. Night time phone:

PERSONAL INFORMATION

16. Birth date:
17. Driver's License Number:
18. Social Security Number:
19. Marital Status (Married, Divorced, Never Married, Gay)
20. Sex:
21. Height:
22. Weight:
23. Occupation:

24. Medical Insurance Provider and member ID:
25. Prescription Insurance Provider and member ID:
26. Do you have a primary care physician?
27. When was your last complete physical examination?
28. What were the results of that exam?

29. Will you have a copy of that report and any labs sent to us (mail or FAX)?

30. (FOR OVER 40) Did you have your prostate examined?
31. (FOR OVER 40) Did you have your PSA checked?
    If so, what was it?

PAST MEDICAL HISTORY

Please indicate if you now have, or have EVER had:
32. Anemia
33. Arthritis
34. Asthma
35. Blood disease
36. Bronchitis
37. Diabetes
38. Emphysema
39. Epilepsy
40. Gout
41. Hepatitis
42. Heart disease
43. High blood pressure
44. High cholesterol
45. Kidney disease
46. Migraines
47. Mononucleosis
48. Pneumonia
49. Psychological problems
50. Rheumatic fever
51. Seizures
52. Stroke
53. Thyroid disease
54. TB
55. Ulcers
56. Urinary tract infections
57. Have you ever had any form of cancer?
    If so, please detail:

PAST SURGICAL HISTORY
What surgeries have you had?

58. Appendectomy
59. Cholecystectomy (gall bladder removal)
60. Mastectomy (removal of breast material—usually for gynocomastia)
61. Tonsillectomy
62. Prostatectomy
63. Hernia repair
64. Other surgeries (please explain):

65. Have you ever been hospitalized (other than for the above mentioned surgeries)?
If so, please list the reason and give approximate date(s):

FAMILY MEDICAL HISTORY
Have your brothers and/or sisters, parents or grandparents, ever had (please tell which family member(s)?

66. Heart attack
67. Diabetes
68. Kidney disease
69. Leukemia
70. Mental disorders
71. Stroke
72. Prostate cancer
73. Other cancer
Please detail ANY of the above:

74. Are you allergic to anything?
75. If yes, what?

76. Do you smoke?

77. If so, how much each day?
78. How long have you smoked?

79. Do you drink alcohol?
How many drinks do you typically have in a week?

80. Do you use any illicit substances (get high)?
If so, which ones?

REVIEW OF SYSTEMS

Do you CURRENTLY have (please circle)?:

81. Head aches
82. Vision changes
83. Hearing changes
84. Chronic sinusitis
85. Allergic sinus problems
86. Any tenderness or sores in your mouth or throat
87. Bloody noses
88. Chronic cough
89. Do you spit up blood?
90. Shortness of breath
91. Chest pain
92. Dizziness
93. Congestive heart failure
94. Palpitations
95. Any form of arrythmia
96. Heart murmur
97. Recurring constipation
98. Recurring diarrhea
99. Gallbladder disease
100. Throw up blood
101. Blood in your stool or black tarry stool
102. Hernia
103. Loss of appetite
104. Indigestion
105. Nausea
106. Vomiting
107. Jaundice (yellow skin)
108. Do your eyes look yellow?
109. Do you have abdominal pain?
If so, please describe and tell where:

110. Pancreatitis
111. Do you urinate alright?
112. Does it hurt when you urinate?
113. Is there any blood in your urine?

114. Have you ever had a STD (Sexually Transmitted Disease)?
115. Tingling in your fingers or toes
116. Acne
    Describe any acne history:

117. Do you ever pass out?
118. Do you have cold intolerance?
119. Do you bruise easily?
120. Depression
121. Anxiety
122. Decreased sexual potency
    If so, is this causing stress in your relationship?
123. Sleep disturbances
124. Generalized muscle aches and pains
125. Joint pain
126. Back pain
127. Fatigue
128. Lethargy
129. Nocturnal emissions
130. Sensitive or swollen nipples?
131. Did you have swollen or painful nipples BEFORE you ever used steroids (for Steroid Consult only)?
132. Can you feel any lumps around your nipples
133. Are you losing your hair?
    Were you losing it before you started using steroids (AAS Consult only)?
    If so, is it falling out more quickly now?

GENERAL

134. Loss of appetite
135. Unexplained weight loss
136. Do you consider yourself to be in good health?
137. Do you sleep well?
    Average hours of sleep per night:

138. Do you regularly self examine your testicles?
139. Tell me about your diet (Details please)

MEDICATIONS

140. Do you take any prescription medications (other than steroids)?
    If so, please list, and give dosages:

141. What supplements do you take (vitamins, minerals, neutraceuticals, etc. List all with amounts or dosages) each day?

142. How much water do you usually drink each day?

QUESTIONS FOR STEROID CONSULT ONLY:

143. Tell us, as accurately as you can which steroids you are going to take, or have taken, for THIS cycle (AAS Consult only):

144. How many times have you been on a steroid cycle (if any)?

145. How long ago was your first steroid cycle (if any)?

146. How long was your break before starting this cycle?

147. Describe your past usage, if any, of hCG, Nolvadex, Clomid, Arimidex or finasteride:

148. Have you ever had any problems (side effects) with any of the medications mentioned in question #147? If so, please describe:

149. Which of the ancillaries are you looking for, and how much of each do you want (AAS Consult only)? **This question is for experienced AAS users only**.

HRT patients only (questions 150-159):

150. Do you plan on having more children?
151. Do you have a decrease in sex drive?
152. If the answer to #151 is "YES", is this affecting your relationship?
153. Has your strength or endurance decreased?
154. Are you enjoying life less?
155. Are you sad or grumpy?
156. Are your erections less strong?
157. Has your work performance decreased?
158. Do you have a hard time recovering from physical activity?
159. Have you ever been on HRT before?

CONGRATULATIONS! YOU ARE (FINALLY!) DONE WITH THIS FORM.

I HAVE COMPLETED THE MEDICAL HISTORY FORM TO THE BEST OF MY KNOWLEDGE. I CERTIFY THAT MY ANSWERS ARE COMPLETE, HONEST AND TRUE.

Signed: _____

Date: _____