Renata Teytelbaum MD, AMMGC

Family Practice
Age Management Medicine

585 Main Street, Suite 101
Dunedin, Florida 34698

P 727.734.6777 F 727.734.6440

Health History Questionnaire

All material in this questionnaire is strictly confidential and will become part of your medical record

Today's Date: _____

Last Name:_____

First Name:_____ Middle Name:_____

DOB:_____/_____/_____ Age:_____ Gender: ❍ Female ❍ Male

Home Address:_____

City:_____State:_____ Zip_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____Email:_____

Preferred Daytime Contact Phone: ❍ Home ❍ Cell ❍ Work

Race/Ethicity:_____

Relationship Status: ❍ Single ❍ Married ❍ Divorced ❍ Separated ❍ Widowed ❍ Partnered

Occupation:_____ Employer:_____

PCP Name & Phone Number:_____

Names of Specialists (if any):_____

Date of Last Physical:_____

Referred By:_____

Main Reason For Visit:_____

Past & Present Medical Conditions and Family History:

	Self History	Family History
Acid Reflux		
Alcoholism		
Allergies		
Anemia		
Anxiety		
Arthritis		
Asthma		
ADD/ADHD		
Bipolar Disease		
Cancer & Type of		
Cataracts		
Clotting Disorders		
Congestive Heart Failure		
Constipation		
Crohn's		
Dementia		
Depression		
Diabetes & Type		
Diarrhea		
Dizziness		
Drug Abuse		
Eating Disorder		
Eczema		
Fibromaylagia		
Glaucoma		
Gluten Sensitivity		
Gout		
Gallbladder disease		
Heart Attack/Angina		
Heart Valve Disorder		
High Blood Pressure		
High Cholesterol		
HIV		
Hyperthyroidism		
Hypothyroidism		
Immune Problems		
Infertility		
Insomnia		
Irregular Heartbeat		
Kidney disease/stones		
Liver Disease/Fatty Liver		
Lyme Disease		
Migraine Headaches		
Multiple Sclerosis		
Obesity		
Osteoporosis		
Peripheral Arterial Disease		
Psoriasis		
Schizophrenia		
Seizures		
Stroke		
Ulcers		

Have you had ❍ Chicken Pox ❍ Measles ❍ Mumps ❍ Polio ❍ Rheumatic Fever

Is your mother ☐ Alive, Age & Current Medical/Psych Problems_____

☐ Deceased, Age at Death & Cause_____

Is your father ☐ Alive, Age & Current Medical/Psych Problems_____

☐ Deceased, Age at Death & Cause_____

Do you have siblings? ❍ No ❍ Yes

Brother(s) (Full & Half), Age(s), Medical/Psych Problems_____

_____

Sister(s) (Full & Half), Age(s), Medical/Psych Problems_____

_____

Past Surgeries & Hospitalizations:

Name/Reason/Diagnosis	Year

Prescribed Pharmaceutical and/or Nutraceutical Medications & Dosages if Known:

_____
_____
_____
_____
_____
_____
_____

OTC Drugs/Vitamins/Supplements/Herbs & Dosages if Known:

_____
_____
_____
_____
_____
_____

Known Drug Allergies/Sensitivities: _____

Known Food Allergies/Sensitivities:_____

Known Environmental Allergies: _____

Lifestyle Questions:

Are you trying to lose weight ❍ No ❍ Yes

If yes, how many pounds?_____ Highest weight_____ Lowest weight_____

Are you following a diet ❍ No ❍ Yes

If yes, type ❍ Doctor Prescribed ❍ Atkins ❍ Mediterranean ❍ South Beach ❍ Raw Food

❍ Vegan ❍ The Zone ❍ Vegetarian ❍ Weight Watchers ❍ NutriSystem ❍ Jenny Craig

❍ Macrobiotic ❍ Cookie ❍ Glycemic Index ❍ Other_____

Do you exercise ❍ No ❍ Yes

If yes, what type of exercise?_____

How many times per week?_____How many minutes per day?_____

Have you ever been a member at a gym?_____ Worked with personal trainer?_____

Do you drink alcohol ❍ No ❍ Yes What is the frequency?_____

Are you dependent on alcohol?_____If so, for how many months/years?_____

What is your preferred alcoholic beverage(s)?_____

Do you currently abuse recreational or prescription drugs ❍ No ❍ Yes

For how long and what types?_____

Do you smoke ❍ No, never ❍ I used to for this many years_____ Packs per day_____

❍ Yes, current use. Number of packs daily_____Since age_____

How many hours of sleep do you get?_____ Is it refreshing/restorative?_____

Do you take naps during the day ❍ No ❍ Yes Do you wake up in the middle of the night ❍ No ❍ Yes

How many times and why?_____

Have you ever been exposed to chemicals?_____

Do you drink coffee ❍ No ❍ Yes ____cups daily Soda ❍ No ❍ Yes ___cups daily ____cups weekly

What type of soda do you drink?_____

Do you drink juice ❍ No ❍ Yes ____cups daily and type(s)_____

Do you use sweeteners ❍ No ❍ Yes, I use this type_____

How many glasses of water do you drink daily?_____ Type of water?_____

What types of cravings do you have ❍ Sweet ❍ Salty ❍ Fatty ❍ Carbs

What are your main sources of protein?_____

How many fruits & vegetables do you eat daily?_____ Types?_____

How often do you eat fast food or at a restaurant?_____How many meals do you eat daily?_____

Do you eat breakfast ❍ No ❍ Yes If yes, what?_____

Describe your lunch_____

Describe your dinner_____

Do you snack between meals? ❍ No ❍ Yes If yes, what?_____

Have you ever seen a therapist or a life coach?_____

At what age did you feel your best? Or do you think it is yet to come?_____

What do you enjoy most in life?_____

What are you most scared of in life?_____

What are your pet peeves?_____

What are your hobbies?_____

Are you religious or spiritual?_____

Do you enjoy your job?_____Do you feel fulfilled in life?_____

What are your life stressors?_____

What is your sexual orientation?_____

Have you ever been abused (physically, emotionally, sexually)?_____

If you are in a relationship, is it healthy?_____ Do you have emotional support?_____

Who is in your household?_____

Do you have pets?_____

How would you describe your personality?_____

Name 3 personal strengths_____

Name 3 personal weaknesses_____

What goals do you want to achieve in life?_____

FOR FEMALES

How many times have you been pregnant total?_____ Living children_____Abortions_____

Miscarriages_____ Pre-term_____ Full-term_____Stillborn_____Ectopic_____

C-sections____# of Vaginal births____Adopted children_____Have you ever been a surrogate?_____

Have you tried IVF?_____ Was it successful?_____

Have you had a mammogram ❍ No ❍ Yes Have you ever had a breast lump ❍ No ❍ Yes

Was the lump benign or malignant?_____

Age of first period_____ Date of your last period_____ ❍ Regular ❍ Irregular

Heavy bleeding ❍ No ❍ Yes Painful periods ❍No ❍ Yes # Days period lasts_____

Are you sexually active ❍ No ❍ Yes Are you satisfied ❍ No ❍ Yes Vaginal dryness ❍ No ❍ Yes

Loss of libido ❍ No ❍ Yes Loss of orgasm ❍ No ❍ Yes Hot flashes/Night sweats ❍ No ❍ Yes

Urine leakage ❍ No ❍ Yes Hair loss ❍ No ❍ Yes Breast tenderness ❍ No ❍ Yes

Mood swings ❍ No ❍ Yes Dry skin/wrinkles ❍ No ❍ Yes Adult Acne ❍ No ❍ Yes

Food cravings ❍ No ❍ Yes Sleep disturbance ❍ No ❍ Yes Fatigue ❍ No ❍ Yes

Wear sunscreen/SPF products ❍ No ❍ Yes

FOR MALES

Loss of aggressiveness ❍ No ❍ Yes Loss of libido ❍ No ❍ Yes Loss of confidence ❍ No ❍ Yes

Difficulty achieving erection ❍ No ❍ Yes Difficulty maintaining erection ❍ No ❍ Yes

Premature ejaculations ❍ No ❍ Yes Performance anxiety ❍ No ❍ Yes

Loss of orgasm ❍ No ❍ Yes Loss of masculinity ❍ No ❍ Yes Irritability ❍ No ❍ Yes

Mood swings ❍ No ❍ Yes Memory loss ❍ No ❍ Yes Sleep disturbance ❍ No ❍ Yes

Breast enlargement/Tenderness ❍ No ❍ Yes Abnormal penile discharge ❍ No ❍ Yes

Prostate problems ❍ No ❍ Yes Skin/Hair problems ❍ No ❍ Yes

Fatigue ❍ No ❍ Yes Increased abdominal girth ❍ No ❍ Yes Loss of muscle tone ❍ No ❍ Yes

SUBMIT