SKYLIMIT™

Integrated Wellness Solutions

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Please complete the Medical History Evaluation form BEFORE your first appointment. Please remember to bring your completed form with you at your first appointment. ***If you do not bring your completed Medical History Evaluation Form, we will have to reschedule the appointment to another date and time.***

You may fax, email, or bring it to the office ahead of time, but please a paper copy with you at the time of visit.

You also may want to bring:

1) Current prescriptions for hormones
2) Current supplements you are taking and also any previous lab results that you have had done in the past 6 months as well.

SKYLIMIT WELLNESS INTEGRATED WELLNESS SOLUTIONS

MALE MEDICAL HISTORY EVALUATION FORM

Today's date: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____ Cell phone: _____

City: _____ State: _____ Zip Code: _____ Home phone: _____

Email address: _____ Do you regularly check email? ___Yes ___No

Height: _____ Weight: _____ Occupation _____

Primary Care Physician/Provider:
Name: _____
Address: _____
Phone: _____ Fax: _____

Alternate doctor:
Name: _____
Address: _____
Phone: _____ Fax: _____

		How often and how much?
Do you use tobacco?	____Yes ____ No	_____
Do you use alcohol?	____Yes ____ No	_____
Do you use caffeine?	____Yes ____ No	_____
Do you exercise regularly?	____Yes ____ No	_____

Describe typical meals.
Breakfast - _____
Lunch - _____
Dinner - _____
Snacks - _____

Allergies: Please list all that apply.
Drugs: _____
Foods: _____
Other: _____
Please describe the allergic reaction when it occurred: _____
_____

Medical Conditions/Diseases: Please check all that apply.

____ Heart disease	____ High cholesterol	____ High blood pressure	____ Cancer
____ Ulcers	____ Thyroid disorder	____ Prostate problems	____ Lung conditions
____ Blood clotting problems	____ Diabetes	____ Arthritis/joint problems	____ Depression
____ Epilepsy	____ Headaches/migraines	____ Eye disease	____ Bipolar disorder
____ Chronic Fatigue Syndrome	____ Lyme disease	____ Schizophrenia	____ Infection: please list
____ Parkinson's disease	____ Irritable Bowel Syndrome	____ Traumatic Brain Injury	____ Fibromyalgia
____ Colitis	____ Fractures	____ Eating Disorder	____ Osteoporosis
____ Kidney trouble	____ Other: please list _____		

Current Hormone Therapies:

Name Strength Date Started How often per day

_____

_____

_____

List hormones previously taken:

Name Strength (if known) Date Started Date Stopped Reason for stopping

_____

_____

_____

Current Prescriptions Medications:

Name Strength Date started How often per day

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Do you have a family history of any of the following?

_____ Cancer Family member(s) _____

_____ Hypertension Family member(s) _____

_____ Heart Disease Family member(s) _____

_____ Thyroid Disease Family member (s) _____

_____ Diabetes Family member(s) _____

_____ Osteoporosis Family member (s) _____

Have you had any of the following tests performed?

PSA _____ Date: _____ Outcome: _____

Colonoscopy _____ Date: _____ Outcome: _____

Rectal Exam _____ Date: _____ Outcome: _____

Blood pressure _____ Date: _____ Outcome: _____

Thyroid tests _____ Date: _____ Outcome: _____

Cholesterol _____ Date: _____ Outcome: _____

Triglycerides _____ Date: _____ Outcome: _____

Glucose _____ Date: _____ Outcome: _____

***If possible, please make copies of any recent lab/test results that would be helpful to us in your treatment**

Please list all **Over-The-Counter (OTC)** items you currently or occasionally use, such as antacids, pain relievers, acid blockers, laxatives, antihistamines, decongestants, cough suppressants, anti-diarrheals, sleep aids, etc. -
Do NOT include Nutritional Supplements

_____
_____
_____

Nutritional/Natural Supplements: Please identify and list the products you are using.
Vitamins (examples: multiple or single vitamins such as B complex, E, C, etc.)_____
_____
Minerals (examples: calcium, magnesium, chromium, etc.)
_____
_____
Herbs (examples: Ginseng, ginkgo biloba, etc.) _____
_____
Enzymes (examples: digestive formulas, CoEnzyme Q10, etc.)_____
_____
Nutrition/Protein supplements (examples: shark cartilage, protein powders, amino acids, fish oils, etc.) _____
_____
Other: _____
_____

What are your goals with BHRT or natural hormone replacement use?

_____
_____

Please write down any questions you have about Bio-Identical Hormone Therapy (BHRT).

_____
_____

ADAM Score
(**A**ndrogen **D**eficiency in **A**ging **M**ales) – The ADAM Score is used by physicians to determine the severity of hypogonadism in male patients.
Please circle/check the question number(s) if it pertains to you:

1. _____Do you have a decrease in libido (sex drive)?
2. _____Do you have a lack of energy?
3. _____Do you have a decrease in strength and/or endurance?
4. _____Have you lost height?
5. _____Have you noticed a decreased "enjoyment of life"?
6. _____Are you sad and/or grumpy?
7. _____Are you erections not as strong?
8. _____Have you noticed a recent deterioration in your ability to play sports?
9. _____Are you feeling asleep after dinner?
10. _____Has there been a recent deterioration in your work performance?

RESULTS: A positive questionnaire is defined as a "YES" to questions 1 or 7 OR any 3 others.

Thyroid Evaluation Form

Please indicate your severity level: **0 = None, 1 = Mild, 2 = Moderate, 3 = Severe**

SYMPTOMS

_____ Depression
_____ Dizziness
_____ Inability to lose weight
_____ Goiter (thyroid enlargement)
_____ Cold Extremities (hands & feet)
_____ Hoarseness
_____ Cold Intolerance
_____ Dry eyes
_____ Sleep disturbances
_____ Slow pulse rate
_____ Dry Hair
_____ Rapid heartbeat
_____ Heart palpitations
_____ Brittle Hair/Nails
_____ Puffy Eyelids/Face
_____ Dry Skin
_____ Acne
_____ Eczema
_____ Foggy Thinking/Forgetfulness
_____ Infertility
_____ Elevated cholesterol
_____ Fatigue
_____ Low libido (sex drive)
_____ Lack of motivation
_____ Constipation

When did these symptoms start?

_____

Is there a family history of ANY thyroid disease? Please list whom and what type (goiter, hypothyroidism, Graves' Disease, Hashimoto's Disease, etc.)

_____
_____
_____

Adrenal Questionnaire

I have not felt well since

_____when_____
(Date) (Describe event, if any)

Predisposing Factors: Check you severity level: 0 = None, 1 = Mild, 2 = Moderate, 3 = Severe

_____ I have experienced long periods of stress that have affected my well-being.
_____ I have had one or more severely stressful events that have affected my well-being
_____ I have driven myself to exhaustion
_____ I overwork with little play or relaxation for extended periods
_____ I have taken long term or intense steroid therapy
_____ I tend to gain weight, especially around the middle (spare tire)
_____ I have a history of alcoholism &/ or drug abuse
_____ I have environmental sensitivities
_____ I have diabetes (type II, adult onset, NIDDM)
_____ I suffer from post-traumatic distress syndrome
_____ I suffer from anorexia
_____ I have one or more other chronic illnesses or diseases

Energy Patterns

_____ I often have to force myself in order to keep going. Everything seems like a chore.
_____ I rely on caffeine and/or sugar to get through the day.
_____ I am easily fatigued
_____ I have difficulty getting up in the morning (don't really wake up until about 10 am)
_____ I suddenly run out of energy
_____ I usually feel much better and fully awake after the noon meal
_____ I often have an afternoon low between 3:00 – 5:00 PM
_____ I get low energy, moody, or foggy if I do not eat regularly
_____ I usually feel my best after 6:00 PM
_____ I am often tired at 9:00 – 10:00 PM, but resist going to bed
_____ I like to sleep late in the morning
_____ My best, most refreshing sleep often comes between 7:00 – 9:00 AM
_____ I often do my best work late at night (early in the morning)
_____ If I don't go to bed by 11:00 PM, I get a second burst of energy which often last until 1:00 – 2:00 AM

Hormone Symptom Survey

Instructions: Please enter the appropriate response number to each question in the columns below.

0 = None/Absent 1 = Mild or Rare 2 = Moderate 3 = Severe

Add an * (asterisk) if symptom is intermittent or "comes & goes".

_____ Burned out feeling
_____ Hot flashes/Night Sweats
_____ Decreased stamina
_____ Apathy
_____ Difficulty sleeping
_____ Decreased libido (sex drive)
_____ Decreased erections/erectile dysfunction
_____ Weight gain - waist
_____ Weight gain – breast/hips
_____ Mental fatigue/decreased mental sharpness
_____ Prostate problems
_____ Increased urinary urge
_____ Decreased urinary flow
_____ Decreased muscle mass
_____ Infertility problems
_____ Insomnia
_____ Oily skin
_____ Irritable

_____ Stress
_____ Aches and pains
_____ Nervousness/Anxiety
_____ Fibromyalgia
_____ Allergies
_____ Chemical sensitivities
_____ Headaches
_____ Sugar cravings
_____ ADD/ADHD
_____ Compulsions/Addictions
_____ Panic attacks
_____ Overwhelmed
_____ Slow recovery from illness
_____ Morning fatigue
_____ Evening fatigue
_____ High cholesterol/triglycerides

Other: _____

What are your top 3 biggest concerns/symptoms?

1. _____
2. _____
3. _____