KINGWOOD HEALTH & WELLNESS CLINIC®

REGISTRATION FORM

(Please Print Clearly)

Today's date:	PCP:

PATIENT INFORMATION

We verify your identity with your Drivers License

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	DL #	Cell:

P.O. box: EMAIL:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.:

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ❑ Business Card ❑ Billboard ❑ Google

❑ Family ❑ Friend ❑ Newspaper ❑ Internet Search Billboard location:

Other family members seen here:

Advance Beneficiary Notice of Non-coverage

I hereby certify that the above information is true and correct to the best of my knowledge. I hereby authorize Kingwood Health & Wellness clinic to release any of my patient information required for continued care to other Providers that I may utilize for my care. I understand and agree, that I am financially responsible for any balance owed for my care This is a fee for service clinic. Payment due on day of service. _________Initial

We will not authorize lab slips or lab testing and that the lab testing must be done outside of any insurance plan Dealing with insurance companies and HRT has been difficult and insurmountable. We, therefore, wish to advise you that your HRT treatment will not involve any use of insurance or completing insurance forms or statement of medical necessity." __________ Initial**

Your telephone number is collected to send appointment reminders as well as clinic specials. You may "opt out" of receiving texts at any time. Please sign below to indicate that you understand and consent to treatment and agree to receive our text reminders._________**Initial**

We strive to achieve optimal health & wellness through nutrition, exercise, hormone balance and optimization. Our programs, protocols and philosophy are designed to maximize your QUALITY of life. If your hormone levels are in a "normal" range but are low and you have symptoms we may start therapy to alleviate symptoms. ._________**Initial**

Patient signature (SIGN HERE) *Date*

REASON FOR VISIT TODAY

Please check the reason you are coming in today; if it is not listed please write in the reason, if doing lab-work what is the reason:

____

____

____

____

- ▫ New weight patient
- ▫ New Hormone
- ▫ B-complex Injection
- ▫ Thyroid Evaluation
- ▫ Botox Injections
- ▫ Laser Evaluation
- ▫ Juverderm/Fillers
- ▫

- ▫ Hormone Imbalance
- ▫ High blood pressure
- ▫ Loss of sexual desire
- ▫ Diabetes
- ▫ Headaches
- ▫ Depression
- ▫ Low Testosterone

(Patient MUST read and sign in order to be seen)

KINGWOOD HEALTH & WELLNESS CLINIC®

Original Date:	05/01/2006
Dates Revised:	1/1/2018

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.)*:	☐ M ☐ F	**DOB:**
Current or referring doctor:	**Date of last physical exam:**	

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List or circle any medical problems that other doctors have diagnosed

☐ Low thyroid	☐ Cancer	☐Elevated PSA
☐ High blood pressure	☐ Depression	☐ Constipation
☐ High Cholesterol	☐ Bipolar	☐ Snoring or sleep apnea
☐ Diabetes (insulin or no-insulin)	☐ Reflux	☐ Waking at night to urinate

Surgeries ☐ **No Surgeries Please list or circle if listed**

Year	Surgery	Thyroidectomy ☐R ☐Left ☐Total
	☐ C-section How many?____________	Gastric ☐ Staple or ☐ Banding
	☐ Hysterectomy ☐ Tubal Ligation	Heart Surgery
	☐ Gallbladder removed (cholecystectomy)	Other:
	☐ Appendectomy	Other:
	☐ Tonsillectomy	Other:
	ANYTHING ELSE:	

Other hospitalizations

Year	Reason	Age if you do not remember year

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins ,inhalers and including birth control

Name the Drug	Strength	Frequency Taken

Allergies to medications ☐ **No Known Drug Allergies**

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

PLEASE ANSWER ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ALL ANSWERS WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting ?			☐ Yes	☐ No
	Have you taken appetite suppressants in the past?			☐ Yes	☐ No
	# of meals you eat in an average day?				
	Rank salt intake	☐ Hi	☐ Med	☐ Low	
	Rank fat intake	☐ Hi	☐ Med	☐ Low	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind? ☐ Beer ☐ Wine ☐ Liquor ☐Tequila ☐Vodka				
	How many drinks per week?				
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit	☐ Do you desire to quit?__________		
Sex	Are you sexually active?			☐ Yes	☐ No

	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you get dizzy on standing?	☐ Yes	☐ No
Quality of Life	HOW WOULD YOU RATE YOUR HEALTH AND WELL-BEING		
	Poor **Fair** **Good** **Very Good** **Excellent** ** This helps us evaluate our treatments, please compare o the best you ever felt health-wise		

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father (F)			**Children** (M)male (F)female	☐ M ☐ F	
Mother (M)				☐ M ☐ F	
Diabetes	☐ M ☐ F			☐ M ☐ F	
Heart Disease	☐ M ☐ F			☐ M ☐ F	
Hypertension	☐ M ☐ F		**Grandmother** *Maternal*		
Thyroid	☐ M ☐ F		**Grandfather** *Maternal*		
Kidney	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

Do you have problems with weight gain or losing weight?	☐ Yes	☐ No
Do you occasionally feel depressed or have depressed moods?	☐ Yes	☐ No
Is your concentration decreased?	☐ Yes	☐ No
Do you have problems with occasional constipation?	☐ Yes	☐ No
How often are bowel movements?		
Do you get cold easily or have cold hands or feet?	☐ Yes	☐ No
Have you noticed excessive hair loss?	☐ Yes	☐ No
Is your skin dry?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Poor energy or fatigue?	☐ Yes	☐ No
Bone / Joint Pain	☐ Yes	☐ No

WOMEN ONLY

DO NOT WRITE N/A, EVERYTHING IS APPLICABLE

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days Length of periods_______days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____ Miscarriage_______Abortions_____		
Are you pregnant or breastfeeding?	☐ **Yes**	☐ **No**
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ **Yes**	☐ **No**
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Date of last pap and rectal exam? Results: ☐ Normal ☐ Abnormal (Please list any findings)		

Date of last mammogram?__________Results: ☐ Normal ☐ Abnormal (Please list any findings)

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam? Results: ☐ Normal ☐ Abnormal (Please list any findings)	☐ Yes	☐ No

OTHER PROBLEMS

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	☐ Hormonal symptoms

I hereby certify that the above information is true and correct to the best of my knowledge.__________