Aspire for Wellness Together

Dr. Sandra Mannon

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Name_____

DOB:_____ Age:_____

Address:_____

City_____ State: _____Zip:_____

Phone _____ E-Mail:_____

Phone Number: _____ Can messages be left: YES ___ NO ___

How did hear about Aspire for Wellness Together? _____

Do you have any allergies, if yes please
list_____

Family History:

Mother _____ Father _____

Brothers _____

Sisters_____

Social History:

Single ___ Divorced ___ Married ___ Significant other ____Occupation _____

Do you have children, if so how many and their ages? Please include if they have any medical diagnosis.

_____

_____

Surgical History:

_____

_____

_____

Do you smoke, if yes how much and when did you start smoking? _____

Do you smoke marijuana _____

Do you use any narcotics even if prescribed by another medical provider _____

Do you drink alcohol, if so how much each week _____

Health History:

When was your last complete physical exam? _____

Females:

When was your last Pelvic exam / Pap Smear? _____ Was it normal or abnormal _____

When was your last mammogram? _____ Was it normal or abnormal _____

Have you had a female hormone panel drawn, if so when? _____

Have you been on hormone replacement, if so are you currently using? _____

REVIEW OF SYSTEMS Place an X if positive

HEENT:

Headaches ___ Migraines ___Dizziness, Vertigo ___ TMJ ___ Vision Issues ___

Hearing Issues ___ Sinus Issues ___ Difficulty Swallowing ___

CARDIVASCULAR:

Heart Disease ___ Heart Attack ___ Heart Surgery ____ Stents ___

Do you take blood thinners ___High Blood Pressure ___ PE ___ DVT ___

Do you have chest pain? ___ Do you have palpitations? ___ Arrhythmias ___

Have you had an abnormal EKG? ___

LUNGS:

COPD ___ Lung Cancer ___ Lung disease ___ Post-Covid Respiratory Issues ___

Do you have shortness of breath? ___ Do you have a chronic Cough? ___ Sleep Apnea ___

GI:

GERD ___

Do you have heart burn? ___ Do you have constipation? ___ Do you have Diarrhea? ___

Do you nausea or vomiting ? ___

GU:

Kidney Disease ___ Kidney Stones ___ UTI ___

Do you have bladder leakage? ___

Do you get up more than 1 time at night to go to the void? ___

MSK:

Back Pain ___ Neck Pain ___ Knee Pain ___ Shoulder Pain ___ Hip Pain ___

Any MSK issues _____

NEURO

Parkinson's ___ Alzheimer's ____ Dementia ___ Seizures ___ Stroke___

Depression ___ Anxiety ___ ADD ___ Other mental Illness _____

Diabetes: Type I ___ Pre-diabetes ___ Type II ___ Last HGAIC, date and # ___

Hypothyroidism ___ Hyperthyroidism ___ Hashimoto's ___

Blood Disorder: Anemia ___ HIV ___

Auto-Immune Disease: RA ___ Other _____

Cancer Diagnosis and treatment, if so when _____

FEMALES:

Pregnancies ___ Miscarriages ___ Vaginal Births ___ C-Sections ___

Are you pregnant now or desiring pregnancy? _____

Birth Control _____ Ablations _____

Are you sexually active ___

Do you still have a period, if so is it regular? _____

Age of Menopause ___ Hysterectomy, complete or partial _____

Hot flashes ___ Night Sweats ___ Breast discomfort ___

Weight gain ___ Weight loss ___ Lack of energy ___ Sleep disturbance ____

Decreased muscle mass ___ Decreased strength/ energy ___

Memory issues ___ Concentration issues ___ Headaches ___

Swelling in feet ___ Bloating ___ Bone Loss ___ Thinning hair ___

Depression ___ Anxiety ___ Mood swings ___

Vaginal dryness ___ Pain with intercourse ___ Decreased Sexual Desire ___

What are you biggest concerns today?

_____
_____
_____
_____
_____

When is the last time you had lab work? _____

If you have insurance, which lab would you like to use? _____

Which pharmacy do you use and what is their phone number and address:

_____
_____
_____

I understand that Aspire for Wellness does not accept insurance plans and I have agreed to pay the cost for each service per the fee schedule which is available in complete format per my request. I agree that the payment will be made on the day of service. If I am having any use of biologics, I understand that I will need to make a payment of 50 % to order the product before the procedure can be scheduled. I have had the opportunity to ask any questions regarding my medical care, services and fees and I agree.

Name _____ Date _____

Signature _____