941-260-7804
4144 20th St W
Bradenton, FL 34205

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? ____

Males:

When was your last PSA checked? ______ Was it normal or abnormal? __________________

Have you had a male 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? ___ D 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 ____

MALES:

Are you sexually active ___Are you able to achieve an Erection ___ Do you have an erection in the am ___

Can you maintain and erection ___ Are you dissatisfied with your erection ___

Do you need to get up during the night more than 1 time to void ___

Do you have a decreased libido ___ Do you have decreased muscle mass ___

Do you have decreased energy levels ___ Do you need to nap in the afternoon ___

Do you sleep well ___ Do you have hair loss ___

Weight gain ___ Increased breast tissue ___ Increased abdominal girth ___

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 ____