ALR
- APEXLIFE REJUVENAT ON -

MALE PATIENT INTAKE FORMS

FIRST & LAST NAME:		**NICKNAME:**	
ADDRESS: **CITY:**		**STATE:**	**ZIP:**
CONTACT NUMBER:		**DRIVER LICENSE NUMBER** (COPY IS REQUIRED UPON CHECK-IN)	
EMAIL:		**OCCUPATION:**	
HEIGHT:	**CURRENT WEIGHT:**	**GOAL WEIGHT:**	**BP if Known:**
BIRTH DATE:	**AGE:**		
EMERGENCY CONTACT:		**CONTACT #:**	**RELATIONSHIP:**
MARITAL STATUS:	Single Married Divorced Widowed Domestic Partnership		
PRIMARY PHYSICIAN:		**DATE OF LAST VISIT:**	
LIST ANY MAJOR HOSPITALIZATIONS, OPERATIONS OR ILLNESS:			

LIST YOUR PRIMARY SYMPTOMS OF CONCERN YOU WANT TO ADDRESS BY PRIORITY

SYMPTOM/CONCERN	DATE OF ONSET	FREQUENCY	SEVERITY

Patient Signature Date

- APEXLIFE REJUVENATION -

FAMILY HISTORY INFORMATION – CHECK ALL THAT APPLY

CHILD	SIBLINGS	FATHER	MOTHER	SELF	DISEASES / DISORDERS	PHYSICIAN NOTES
					ABNORMAL BLOOD PRESSURE	
					ARTHRITIS OR JOINT PROBLEMS	
					ASTHMA, BRONCHITIS	
					AUTOIMMUNE DISEASE	
					BLOOD DISORDERS/ANEMIA	
					CANCER/TUMORS/CYSTS	
					COLITIS	
					CROHN'S DISEASE	
					DEPRESSION/MENTAL ILLNESS	
					DIABETES	
					ECZEMA/PSORIASIS	
					ENDOCRINE DISORDER	
					EPILEPSY	
					EXCESSIVE BLEEDING	
					GALL STONES	
					HEART DISEASE	
					HERPES/COLD SORES	
					HIV	
					HEPATITIS	
					JAUNDICE/LIVER DISEASE	
					KELOID SCARRING	
					KIDNEY INFECTIONS/STONES	
					EMPHYSEMA	
					MELANOMA/SKIN CANCER	
					PNEUMONIA	
					REOCCURRING INFECTIONS	
					RHEUMATIC FEVER	
					RHEUMATOID ARTHRITIS	
					THYROID DISEASE	
					TUBERCULOSIS	
					SEIZURES	
					STROKE	
					ULCERS	

LIST CURRENT RX MEDICINES & USED WITHIN PAST 6 MONTHS

CHECK ALL THAT APPLY

BLOATING, GAS, FLATULENCE		HAIR LOSS - FALLING OUT		SENSITIVE TO COLD	
HEARTBURN, REFLUX		DRY HAIR		PALPITATIONS/FLUTTERS	
CONSTIPATION		THINNING HAIR		DIFFICULTY GETTING TO SLEEP	
HEMORRHOIDS		NAUSEA/VOMITING		INSOMNIA	
BOWEL HABIT CHANGES		EARS RINGING/DIZZINESS		PSORIASIS/ACNE FLAREUPS	
COUGHING/WHEEZING		FATIGUE		DRY SKIN	
FOOD ALLERGIES/INTOLERANCES		TIRED UPON WAKING		URINARY TRACT INFECTIONS	
SEASONAL ALLERGIES/HAY FEVER		FRONTAL HEADACHES/SINUSITIS		ARTHRITIS/JOINT ACHES & PAINS	
CRAVINGS - SWEETS		COLD HANDS/FEET		LOWER BACK PAIN/STIFFNESS	
CRAVINGS - SALT		POOR CIRCULATION		DEPRESSION, WEEPINESS	
CRAVINGS – BEER, WINE, LIQUOR		PUFFY FACE, SWOLLEN EYELIDS IN MORNING		ANXIETY, IRRITABILITY, TEMPER	

MALE HORMONE HISTORY

FIRST & LAST NAME:	
ARE YOU PRESENTLY SERVING, OR IN THE PAST SERVED, IN ANY BRANCH OF ARMED SERVICES:	**YEARS SERVED:**
HAVE YOU HAD PROSTATE EXAM:	**IF YES, DATE OF TEST:**
HAVE YOU HAD A COLONOSCOPY:	**IF YES, DATE OF TEST:**
HAVE YOU HAD A CARDIAC STRESS TEST:	**IF YES, DATE OF TEST:**
HAVE YOU HAD A PSA (PROSTATE SPECIFIC ANTIGEN) BLOOD TEST:	**IF YES, WHAT WERE THE RESULTS:**
ARE YOU CURRENTLY TAKING ANY HORMONES (I.E. TESTOSTERONE, HGH, HCG)?	**IF YES, HOW LONG:**
LIST WHAT YOU ARE CURRENTLY TAKING:	
HAVE YOU PREVIOUSLY TAKEN HORMONES (I.E. TESTOSTERONE, HGH, HCG)?	**IF YES, HOW LONG:**
LIST WHAT YOU HAVE TAKEN:	
EXPLAIN ANY PROBLEMS, PAST OR PRESENT:	
HAVE YOU EVER USED SEXUAL ENHANCEMENT DRUGS OR HERBS (I.E. VIAGRA, CIALIS):	**IF YES, WHAT?**
WHAT IS YOUR NORMAL BEDTIME:	**WHAT IS YOUR NORMAL WAKING TIME:**
DO YOU HAVE TROUBLE FALLING ASLEEP:	**DO YOU WAKE UP TIERD?** **YES / NO / SOMETIMES**
DO YOU WAKE DURING THE NIGHT:	**IF YES, HOW MANY TIMES:**
HOW OLD DO YOU FEEL:	

CHECK ALL SYMPTOMS THAT APPLY (EVEN MILDLY)

LOSS OF STRENGTH		REDUCED LIBIDO AND SEXUAL ENERGY		LOSS OF MUSCLE TONE	
NOT PHYSICIALLY FIT		ERECTILE DYSFUNCTION		INCREASED BELLY FAT	
PERSPIRE HEAVILY DAY AND/OR NIGHT		IRRITABLE AND AGGRESSIVE BEHAVIOUR		FATIGUED, FEELING EXHAUSTED	
DRY SKIN – ESPECIALLY FACE AND HANDS		LOSS OF SELF-CONTROL		MEMORY LAPSES/ MENTAL FOG	
THINNING HAIR OR BALDNESS		RESTLESS, LIGHT SLEEP		UNABLE TO CONCENTRATE	
GYNECOMASTIA (ENLARGED BREASTS)		ANXIOUS		URINARY PROBLEMS	
DEPRESSED, IN LOW SPIRITS		ALWAYS FEELING STRESSED		**FEELING STRESSED**	
RELATIONSHIP ISSUES W/ PARTNER		DRINK A LOT		**JOINTS HURTING**	

SCORE EACH FROM 0 – 10, WITH 10 BEING HIGHEST:

CURRENT LEVEL OF BACK PAIN	STRESS LEVEL PAST 30 DAYS	ENERGY LEVEL IN MORNING
CURRENT LEVEL OF JOINT PAIN	STRESS LEVEL PAST 6 MONTHS	ENERGY LEVEL IN LATE AFTERNOON

IMPORTANT – PLEASE READ CAREFULLY BEFORE SIGNING: I certify that the information provided is true and correct and that I am a competent adult of at least 40 years of age, FURTHER, I UNDERSTAND A COMPLIMENTARY CONSULTATION IS PROVIDED BY THE PHYSICIAN'S APPOINTED NON-MEDICAL REPRESENTATIVE AND IS STRICTLY TO PROVIDE PROGRAM/TREATMENT INFORMATION. ANY DIAGNOSIS AND/OR TREATMENT MUST BE MADE BY THE LICENSED PHYSICIAN DURING THE PHYSICIAN FACE-TO-FACE CONSULTATION.

Patient Signature _____ Date _____