Welcome to Lifealize!

Please fill out your medical history in the form below so we can craft your customized treatment program.

* Required

1. Today's Date *

Example: January 1, 2019

2. Full Name *

3. Occupation

4. Street Address *

5. City *

6. State *

7. Zip Code *

8. Reason for Visit *

Confidential Medical History

9. Date of Birth *

Example: January 1, 2019

10. Sex at Birth *

Mark only one oval.

- Female
- Male

11. Height *

12. Weight *

13. Primary Doctor Name *

14. Primary Doctor Phone Number *

15. Date of Last Physical *

****Lifealize Doctors do not treat patients for athletic performance or enhancement****

16. **Questions for Treatment:** *

Do you currently have or have you ever had any of the following symptoms? If yes, please check the corresponding box and explain below.

Check all that apply.

- Decreased Desire to Exercise
- Decreased Energy or Endurance
- Issues With Memory
- Decreased Muscle Strength
- Thinning or Excessive Hair Loss
- Headaches/Migraines
- Dry Skin with Poor Elasticity
- Increased Fat Around Abdomen or Thighs
- Cold or Heat Intolerance
- Increasingly Stressed
- Loss of Interest in Sex/Low Libido
- Difficulty Achieving or Maintaining Erections
- Loss of Concentration
- Feelings of Depression
- Excessive Weight Gain
- Trouble Sleeping
- None of the above
- Other: _____

17. If Yes, Please Explain.

18. **Diagnosed History of Disease:** *

Do you currently have or have you ever had any of the following? If yes, please check the corresponding box and explain below.

Check all that apply.

- Allergies to Medications
- Anemia
- Anxiety
- Arthritis
- Asthma/COPD
- Back Problems/Injuries
- Blood Clots/Pulmonary Embolism
- Blood Disorder
- Cancer
- Chemical Dependency
- Depression
- Diabetes
- Erectile Dysfunction
- Fibromyalgia
- Heart Failure/Heart Attack
- High Blood Pressure
- Immune Disorders
- Lipid Disorder
- Liver Disease
- Neurological Disorder
- Orthopedic/Muscle Disorder
- Prostate Disease
- Renal Disease
- Sleep Apnea
- Thyroid Disease
- None of the above
- Other: _____

19. If Yes, Please Explain.

20. Please list an allergies you have to medication: *

21. Please list all of the medications (prescription and over the counter) vitamins and supplements you are currently taking. Please be specific (name, dosage, etc): *

22. Please discuss any surgeries, hospitalizations, or additional information below: *

23. **Family History:** *

Does an immediate family member currently have or have they ever had any of the following? If yes, please check the corresponding box and explain below.

Check all that apply.

- Heart Disease
- Diabetes
- Thyroid Problems
- High Blood Pressure
- Cholesterol Problems
- Cancer
- Osteoporosis
- Anemia
- None of the above
- Other: _____

24. If Yes, Please Explain.

Lifestyle Information

25. Do you Smoke? If yes, how much do you smoke in a day? *

26. Do you drink alcohol? If yes, how much do you drink per week? *

27. Do you exercise regularly? If yes, how many times do you exercise per week? *

28. Do you have trouble sleeping? If yes, please explain. *

29. **FILL IN WITH AGREEMENT FORMS** *

Patient Agreement and Release
Medication Management Agreement
Telemedicine Consent Form
Notice of Privacy Practices

30. Patient Name *

31. Address *

32. Patient Signature *

33. Date Signed *

Example: January 1, 2019